Ontario

A Report
of the
Ontario Council of Health

1978

Health Care for The Aged

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A Report of the Ontario Council of Health,
senior advisory body to the
Minister of Health

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Published by
The Ontario Council of Health,
700 Bay Street, 14th floor,
Toronto, Ontario.
M5G 1Z6

ISBN 0-7743-3372-3

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Office of the
Chairman

Ontario Council
of Health

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Toronto, Ontario
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June 12, 1978

Honourable Dennis R. Timbrell,
Minister of Health,
10th floor, Hepburn Block,
Queen's Park,
Toronto, Ontario

Dear Mr. Timbrell:

The attached report on Health Care for the Aged is submitted herewith for your consideration.

The Task Force on Health Care for the Aged presented its report to the Ontario Council of Health on May 16, 1978.

Council received the report and endorsed the recommendations given particular emphasis by the Task Force in the chapter entitled "Summary and Recommendations".

The development of this report was of special interest to Council as they realize the aging of our population can place heavy demands on health services in the very near future. They believe special planning for this eventuation should commence immediately in order that steps may be taken in an orderly and effective manner to deal with the problem.

The Council wishes to record its appreciation and thanks to Dr. Albert Rose and members of his Task Force for their efforts in developing this comprehensive and informative document.

Yours very truly,

S. W. Martin,
Chairman.

Att.

Report of The Task Force on Health Care For The Aged

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Membership of The Task Force

CHAIRMAN: Dr. Albert Rose, B.A., M.A., Ph.D., Professor of Social Work, University of Toronto.

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SECRETARY: Mrs. Elizabeth Head, Ontario Council of Health.

Acknowledgements

Members of the Task Force on Health Care for the Aged would like to acknowledge the contributions of the following people who made special presentations to the Task Force.

Dr. Peter Alberti, Mount Sinai Hospital; Consultant to Workmen's Compensation Board.

Dr. David Banting, Department of Community Dentistry, Faculty of Dentistry, University of Western Ontario, London.

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Dr. Irwin Lightman, Baycrest Centre for Geriatric Care.

Mrs. Marilyn Marsh, President, Ontario Physiotherapy Association.

Mrs. Frances McHale, London; Member, Board of Ontario Housing Corporation; Member, Geriatric Research Committee.

Dr. J. C. McCulloch, Chairman, Department of Ophthalmology, Faculty of Medicine, University of Toronto.

Dr. Marvin Miller, Chief, Psychiatric Services, Baycrest Centre for Geriatric Care.

Mr. Douglas Rappelje, Sunset Haven, Welland.

Dr. Dorothy Smith, D.Ph., Sunnybrook Hospital, Toronto.

Mr. Malcolm Walker, Executive Director, Ontario Nursing Home Association.

Miss Sally Weir, Occupational Therapist, Metropolitan Toronto Homes for the Aged.

Mr. W. R. Wensley, Registrar, Ontario College of Pharmacy, Toronto.

Dr. M. E. Woodruff, Director, School of Optometry, University of Toronto.

In addition, the Task Force discussed with a group of elderly people the problems they experience in obtaining health care services and suggestions they may have for improvements in the system. The group were members of the Second Mile Club in Toronto and proved to be most helpful in understanding the needs at the consumer level.

Terms of Reference

General

To determine what needs are peculiar to the aged in the present delivery of health care in Ontario and to determine what additional problems lie ahead in this field in light of current government plans and of any present or likely future trends. To identify strengths and weaknesses and make recommendations for improvement in the system of health care delivery to the aged in Ontario.

Specific

1. To determine what health care needs of the aged are distinctly different from those of the rest of the population.
2. To examine the different health care needs of various subgroups of the elderly, such as the "young old" and the "old old".
3. To determine the effect the increasing number and percentage of aged in the population will have on the future delivery of health care in Ontario.
4. To identify special problems in the delivery of health care services to the aged and to judge the effectiveness of the present services.
5. To consider the financial and personal costs of caring for the elderly in different environments.
6. To determine how the training and education of health care personnel should be altered or modified by the requirement for adequate health care for the aged.
7. To determine the extent to which health care needs of the aged and their solutions are linked to other aspects affecting aging in our society (e.g. social services, housing, recreation, employment, income, etc.).

Preface

The Task Force was established by the Health Services Committee of the Ontario Council of Health in November 1976, in response to a specific request by the Minister of Health for Ontario. It met for the first time in December 1976, and in the intervening period has held 16 meetings, during which it received presentations from its own members and specialists in fields of particular concern in the delivery of health care and related social services to the aged.

From the beginning of its deliberations the Task Force recognized that the provision of health care for the aged is merely one important aspect of the broad field of gerontology. Moreover, the process of aging on the one hand and the concept of health care on the other, are potentially so broad that they are almost without limits.

There are, in addition, a number of aspects including the social services, housing accommodation, recreational services, employment opportunities, and income maintenance that affect the health of the elderly, as well as all members of the total population, but which cannot be explored in depth in an examination of the health care needs of the elderly. The way in which government is organized to provide services to certain groups in the population is also a matter of significance, particularly with respect to the relationships between the health services and the social services.

Although it appears that the people of Ontario have only recently come to realize that the number of persons over the age of 65 is already impressive and is projected to increase substantially during the balance of this century, it is a fact that a good deal of research and study has been devoted to the problems of older people in Canada, in Ontario and in several provinces. The roster of important published investigations includes:

Report of the Survey Committee on the Aged and Long Term Illness, Province of Saskatchewan, 1963.

Report of the Special Committee on Aging of the Senate of Canada, Government of Canada, 1965.

Final Recommendations of the Select Committee on Aging of the Legislature of Ontario, Province of Ontario, 1967.

Report of the Nova Scotia Council of Health on Health Care in Nova Scotia, 1972.

Report on Health Security for British Columbians, Ministry of Health, Government of British Columbia, 1973.

"Aging in Manitoba: Needs and Resources 1971", Manitoba Department of Health and Social Development, 1975.

"Health Services for the Elderly", Final Report of a Working Group of the Federal-Provincial Advisory Committee on Community Health, Health and Welfare Canada, 1976.

There are available many international studies instituted by the World Health Organization, as well as major investigations initiated in the United States, United Kingdom and the several countries of Scandinavia.

The contribution of a Task Force on Health Care for the Aged, under the auspices of the Ontario Council of Health must, therefore, depend upon the latest information concerning the needs of the elderly in Ontario and the resources available to meet them. In the report which follows, some attention is paid to all relevant aspects of the lives of older people, but such matters as income maintenance, housing, retirement policies and the like are not examined in depth.

It was not possible to accomplish the task suggested in the fifth term of reference respecting the financial and personal costs of caring for the elderly in different environmental settings. Attention is drawn, therefore, to the fact that the Economic Council of Ontario has undertaken a study of these matters as a part of an economic analysis of the costs of health care for the elderly.

The report is structured so as to meet the requirements of two different groups of readers. Those who wish to ascertain the views of the Task Force in terms of its recommendations and a brief overview of its approach to the study may wish to read only to the end of the Chapter entitled 'Summary and Conclusions'. Those who wish to gain a more complete undertanding of the work of the Task Force, its consultations with specialists in a variety of fields and the intensive discussions which led to recommendations, will find the main body of the Report in four chapters and several appendices following the Recommendations and Summary chapter. A more detailed record of the consultations is on file in the offices of the Ontario Council of Health and may be examined there on appropriate request.

Summary and Conclusions

At a time of economic restraint, budgetary deficits, unemployment and price inflation, it may be difficult for the people of Ontario to consider and plan for the requirements of elderly persons in this province two or three decades hence. Nevertheless, in the view of the Task Force, such consideration and planning are urgently required and should begin as soon as possible.

Once the people of Ontario are given the facts, once the nature and potential extent of the problems of the future are revealed, once the requirements for policy formulation, organizational change and alternative systems are delineated, we believe the response will be supportive of the elderly and their fundamental needs. What is needed, in the first instance, is a clear declaration of policy by the Premier of Ontario that the government understands these concerns and is committed to continuous and strengthened support for Ontario's substantial population of older people.

The Facts

The number and proportion of elderly persons (65 years of age and over) in Ontario are increasing steadily and significantly. On the basis of population projections published by Statistics Canada for each year from the early 1970's through the census year 2001, the estimated number of Ontario's elderly in 1978 is approximately 770,000. By the end of the century this number will be approximately 1,300,000. The percentage of Ontario's population which is 65 years of age and over at the present time is approaching 9.0; this figure is projected to increase to about 13 percent by the year 2001.

Elderly persons are not only increasing in absolute and relative terms but it is a fact that in general they are living longer and that the greatest increases are occurring in the oldest age groups. During the balance of the century the percentage increase among persons 85 years of age and over will greatly exceed increases among those who are 75-84 years of age and those who are 65-74 years of age. Increasing longevity and better health care have changed the views of many professionals and health scientists about the determination of the age at which the term elderly ought to be applied. There has emerged a simple series of terminology which designates those who are 65-74 years of age as "young-old"; those who are 75-84 years of age as "middle-old"; and those who are 85 years of age and over as "old-old".

In a study of the health care needs of the aged in Ontario it is not simply a matter of the number and proportion of persons who fall within specific age groupings. The utilization of health care services by older persons is a matter of substantial interest and significance. Recent data from the Ministry of Health for the fiscal year ending March 31, 1977, indicate the following proportions of all OHIP services rendered by specific medical and other specialities to persons 65 years of age and over, for example, therapeutic radiologists, 35.86%; physiatrists, 32.68%; urologists, 28.16%; osteopathists, 24.95%; ophthalmologists, 24.63%; general surgeons, 23.17%; internists, 22.56%; and general practitioners, 17.14%. These are only a portion of the available data but they give an important indication of the utilization of health services by elderly persons in Ontario and, in fact, the percentage of services of all practitioners utilized by persons 65 years of age and over, was 16.21%*. It should be reiterated at this point that the proportion of such persons in the Ontario population in fiscal 1976 was less than 9%.

The Problems

Population projections are based upon such variables as fertility, net migration (immigration less emigration), inter-provincial migration, and mortality. It is a fact that these variables may change within the balance of the century. The *proportion* of total population made up by those who are considered elderly can change as a consequence of a sudden shift in the birth rate, opposite to that which occurred shortly after 1960; or by virtue of a substantial increase in immigration to Canada and to Ontario, particularly of young adults and children. The *number* of persons 65 years of age and over, however, will not change in any significant degree from the figures already quoted.

Ontario thus faces the prospect of meeting as far as possible the health care needs of at least 1¼ million persons 65 years of age and over a little more than 20 years hence. If these individuals merely utilize a proportion of available health care services equivalent to their proportion in the population, the problem of supplying health care services would be significant, but perhaps not more difficult than it is at present. The facts of utilization, however, indicate that elderly persons utilize the services of health care professionals at twice the rate of their proportion in the population, and in view of their increasing age as time passes it is probable that this rate of utilization will increase further. The Task Force estimates that 13 percent of the population of Ontario at the end

*The overall average is depressed by relatively lesser utilization of the services of obstetrician-gynaecologists, dental surgeons, oral surgeons, and psychiatrists in private practice.

of the century may well utilize 30 percent of all services rendered among those now chargeable to OHIP.

A statement of a potential problem in supplying a sufficiency of health care services for the elderly and for the entire population of the province a few years hence is sufficiently important in itself, but it is not by any means the entire picture. First of all, it is not a fact at the present time that there is a sufficient supply of services available to meet every health care requirement among the elderly. This point is made with respect to deficiencies in health personnel encountered by the Task Force in its consultations with a variety of health care professionals.

It is clear as well that the data provided with respect to the utilization of OHIP-financed services do not provide the entire picture of the health care requirements of Ontario's older population. The health care needs of the elderly are provided in part through services of many health care professionals other than medical practitioners. The elderly, as well as other segments of the population, are served by dentists, nurses, pharmacists, physiotherapists, occupational therapists, chiropodists, social workers, and by a number of para-professionals, among whom homemakers are perhaps the most significant. The rates of utilization of the services of these various groups are not clearly recorded, but the Task Force learned that nurses, physiotherapists, occupational therapists, social workers, and certainly homemakers, devote a substantial part of their total effort to the needs of the elderly persons in Ontario.

The problem of the availability of professional staff was an open question throughout the deliberations of the Task Force. Consultations were held with health care professionals with a particular interest in the care of elderly people in such diverse fields as, hearing problems (otology), care of the eyes (ophthalmology and optometry), mental health (psycho-geriatrics), dentistry and pharmacy. In addition, representatives of the professions of nursing, physiotherapy and occupational therapy addressed the Task Force. The whole matter of residential care was explored with specialists in the fields of housing, institutional facilities, and nursing homes.

One major aspect of these diverse consultations was focused upon the matter of availability of personnel, including professional staff, para-professionals, and persons with auxiliary status. It was learned that there are already important deficiencies and that certainly within a decade or more, requirements for additional personnel must be met if current levels of service are to be provided to far larger numbers of people. Current and future shortages of personnel depend, however, upon certain

assumptions concerning the provision of services as will become apparent in this report.

There is already a shortage of audiologists (professionals trained in the measurements of hearing loss) and there will be a substantial shortage of hearing aid technicians if the barrier of cost to the acquisition of such devices is removed, as the Task Force has recommended, and if programs of training and follow-up are instituted. There is a shortage of optometrists in this province. The utilization data for psychiatrists suggests that there may be a shortage devoted to providing mental health services for elderly persons, but this cannot be judged fairly from OHIP data. A number of psychiatrists are employed in mental hospitals and mental health clinics and the services provided in those settings to elderly persons would not be revealed in the aforementioned data.

If the present generation of young adults and younger middle aged persons retain their own teeth through better preventive dental services than their forebears, there will be an important shortage of dentists to serve elderly persons at the close of the century or early thereafter. There are already shortages of physiotherapists, occupational therapists, and social workers whose services are performed within the health care system. Finally, there may be a shortage of a variety of para-professional and auxiliary personnel to assist elderly persons in maintaining residence in their own homes and in their own communities, through the provision of a variety of relatively simple services which for the most part fall under the heading of "activities of daily living".

As far as medical practitioners and specialists are concerned it is not evident at the present time that shortages exist overall. The major problem in the late 1970's is one of distribution throughout the province of Ontario. There is, for example, a sufficient number of ophthalmologists in Ontario and the ratios which members of that profession suggest are appropriate (1:30,000 people) are now met, but these specialists are concentrated in the major urban centres in Ontario. As a consequence, an elderly person in Metropolitan Toronto may be required to wait only 3 or 4 weeks for a cataract operation when this is judged essential. In Northern Ontario, on the other hand, the waiting period may be in the order of 2 to 3 months, a situation almost entirely related to the shortage of ophthalmologists in different regions of the province.

The problem of residential care is a serious matter for future planning in the light of the facts concerning increasingly longevity, the increase of aging within the elderly population itself, and the overall shortage of

appropriate accommodation when required. Most persons in the young-old group are able to maintain themselves reasonably well in their own housing accommodation. In 1978 there are more than 30,000 senior citizens' apartments in the province outside of Metro Toronto under the jurisdiction of local housing authorities responsible to the Ministry of Housing; plus an additional 10,000 apartments within Metropolitan Toronto. Those elderly persons who are on the waiting lists in various communities may find that the costs of housing accommodation, whether rented or owned, impair their capacity to maintain an adequate standard of living. The allocation of well above 25% of gross income to shelter costs as now occurs, may thus indirectly affect the health requirements of one group of elderly persons.

The need for institutional types of residential care is likely to occur after age 75 and becomes particularly important among the old-old, those 85 years of age and older. The requirement may be for accommodation in a nursing home, a chronic care facility, or a home for the aged. These several types of residential care are already in short supply in various parts of Ontario. Nursing homes, which are licensed by the Ministry of Health, and which receive a substantial proportion of their funding from the Ministry on behalf of their patients, have difficulty maintaining meaningful waiting lists because, the Task Force was informed, there are simply too many persons in need of too few beds. Although there are waiting lists for homes for the aged, which are under the jurisdiction of the Ministry of Community and Social Services, there is no question that the demand for accommodation exceeds the supply.

There is a further significant problem within this area of appropriate residential accommodation. Recent studies in London and Kingston indicate clearly that at any one time an important proportion of the residents of any of the three major types indicated – nursing homes, chronic care facilities, and homes for the aged – are inappropriately placed. In short, many persons in each of these facilities would be better accommodated in one of the other types of residential care. Moreover, the studies reveal that an important proportion, up to one-twelfth in the London study, are placed in residential facilities and are judged to be quite capable of taking care of themselves in the general community. Thus Ontario already faces the problem of scarce accommodation occupied in part by persons who do not require such residential care, and the fact that many individuals would be better accommodated in another facility than the one which they currently occupy. These factors accentuate gross shortages, where they exist, and can only be remedied,

in the view of the Task Force, through the wide-spread creation of Placement Coordination Services throughout the province. At the present time few such services exist under the previous designation of "assessment and placement services".

In summary, the Task Force is concerned that within a few years there will be an overall shortage of appropriate health care services to meet the needs of much larger numbers of elderly persons throughout the province. The addition of large numbers of medical personnel has not been recommended but it has become quite clear that the educational programs of physicians, dentists, nurses, therapists of various kinds, do not include more than passing reference to the problems of and treatment for disease among elderly persons. There are few geriatricians in the province of Ontario and the Task Force concludes that an additional relatively small number is required, primarily to perform the role of specialist consultants. At the same time, it is strongly affirmed that every practitioner, and physicians proceeding into nearly every specialized practice should receive much more education and clinical training concerning the health care needs of elderly persons who, inevitably, will constitute a larger proportion of their professional practice than is the case at the present time.

Improvement in education for professionals in the health care system must be coupled with much greater research than has been previously devoted to the process of aging, the biology of aging, the pharmacology of aging, and a host of problems which have not been popular among researchers in the health care system. The Task Force has recommended that special priority be assigned by funding bodies within the Ministry of Health and the Ministry of Community and Social Services to research in gerontology, the broad field of aging, in its biological, psychological and social aspects.

In 1978 in Ontario, about 60,000 elderly persons are residents in institutional facilities. This proportion of persons 65 years of age and older, about 7-8%, is considered by gerontologists to be relatively high, by comparison with the experience in other developed countries. The Task Force is concerned that the health care system places a premium upon institutional living through its funding mechanisms and has recommended that far more incentives should be offered to the community and to elderly persons to remain independent as long as possible. To accomplish these objectives the policies within the system designed to meet the health care needs of the elderly, the organization of the health care system, and alternative forms of delivery of service were examined carefully in the proceedings of the Task Force.

The Policies

Among the provinces, the government and the people of Ontario have been relatively generous to our elderly residents. Federal-provincial income maintenance programs have been supplemented by the GAINS program with the result that as of January 1st, 1978, each elderly person in Ontario, with few exceptions, is guaranteed a monthly income of approximately $300. Nevertheless, there is concern with respect to those elderly persons who by virtue of their newcomer status, lack of residence in the province, or for other reasons, do not receive the full income to which the majority are entitled. Some elderly persons in Ontario do not receive sufficient income even at the guaranteed minimum.

The level of income provided must be related to the expenditure patterns of elderly persons and these in turn are affected seriously by either the costs of housing accommodation, or certain health costs which are not covered through the Ontario Health Insurance Plan, or by virtue of both circumstances. The Task Force concludes that there is a substantial requirement for careful studies of an appropriate standard of living for elderly persons in various regions throughout the province, to take into account the rural-urban differentials, and to give due attention to the particularly high shelter costs experienced by many elderly persons within the larger urban centres.

Those aspects of the health care system which are specifically directed toward the needs of older persons in the province are also generous, in the view of the Task Force. Persons aged 65 and over in Ontario are enrolled in OHIP without payment of premiums and receive significant additional benefits in the form of prescribed drugs and medications without direct cost. Moreover, there is no question that services for the health care needs of the aged do exist in most communities in Ontario and in the form of community clinics, out-patient clinics in hospitals, home care programs (to which further attention is devoted later in this report) and chronic care facilities, go far toward meeting the requirements. Nevertheless, the common problem of maldistribution of health care facilities, of health care personnel, and of health care programs, is so evident and so much a matter of concern for the future, that the Task Force wishes to place particular emphasis upon this factor. It concludes that the mechanisms of planning for the future must be put in place as quickly as possible within the Ministry of Health and together with other Ministries which are directly concerned with services to the elderly, but in particular, attention must be paid to the geographical maldistribution of services for elderly persons throughout the province.

There are, of course, differences of opinion concerning the impact of particular policies within the government of Ontario as they affect the health care needs of the elderly. In one view the health care system is geared toward the utilization of institutional facilities and encourages elderly persons to give up their own homes in their own communities and to enter such institutions. This argument is based upon the manner in which funds are available for placement in various institutions while income supplements are not available to give strong support to independent living by elderly persons in their own homes. While these matters are implicit within certain policies implemented by the Ministries of Health and Community and Social Services respectively, they extend beyond these Ministries to the Ministry of Housing and the Ministry of the Treasury.

Older persons can be encouraged to remain autonomous, and outside the institutional system, if the impact of certain specific housing and taxation policies upon them were reduced. The Task Force concludes that many persons who wish to remain in independent living accommodation in the community would be able to do so if, in rental accommodation, they received supplementary income in the same manner in which the rent supplement program is implemented for persons who have applied for public housing accommodation. In the field of taxation the impact of rapidly rising local tax levies upon the living standards of elderly homeowners has not been carefully studied, but there is no question that a good many older persons cannot afford to remain in homes which they have owned and paid for completely over a period of years. The Task Force concludes that the Ministry of Treasury, Economics and Intergovernmental Affairs should be directed to develop tax credit systems whereby elderly persons are protected in greater measure. In the long run the people of Ontario pay far greater amounts to maintain elderly persons in a variety of long term care facilities than would be lost if the tax levies upon elderly persons were further reduced through a tax credit system.

On the other hand, there are specialists in the field of services to the elderly who argue that for many persons residence in institutional or long term care facilities should not be denigrated and in fact, many persons willingly seek such accommodation because it promises contact with people, social and recreational programs, and nutritious and regular meals. It is argued that we should not impede the willingness and desire of some persons to enter the institutional system. The Task Force concludes that this argument is worth consideration and in its proposal that Placement Coordination Services be extended throughout

the province, it affirms that the essential requirements of each elderly person for appropriate residential accommodation must be carefully assessed. To continue to allow the system to operate as it has been as a matter of individual determination on the one hand, and the application of chance factors on the other, will prove far more detrimental to elderly people and far more costly to the province as a whole than the modest costs involved in the development of placement coordination services and home care programs.

Although the Task Force accepted the view of many of its consultants that the elderly are generally well served through the health care system in Ontario, there are important weaknesses and questions for public policy. It is not at all certain that the policies and procedures with respect to losses in hearing and eyesight with the passage of years are properly monitored and properly treated, in terms of the numbers who receive appropriate and adequate care. We have learned that there are too many persons within the health care system who base their views and approaches to policy and practice on the assumption that many of the requirements of elderly people are the inevitable results of aging and are therefore "normal".

On the other hand the Task Force learned that while there may be a normal loss in hearing capacity as aging proceeds, such loss is accentuated by the environmental noise in the work place and is therefore preventable in part, and the treatment of such loss is weakened by the cost barrier to the acquisition of a hearing aid. The fact that there is no program of follow-up and training for persons who do manage to acquire hearing aids is a significant weakness in the system and represents a lack of policy.

As far as eyesight is concerned the Task Force learned that some persons, particularly those who have been surveyed in long term care facilities, may not have a thorough ocular examination for several years at a time. The Task Force concludes that in these two important areas of health, hearing and eyesight, health care policies can be strengthened, prevention can be taught and implemented, and treatment can be provided more systematically.

A further case in point is found within the Drug Benefit Plan, generously provided through the Ministry of Health. Under this plan elderly persons and individuals and families in receipt of certain social assistance payments, receive without cost drugs and medications prescribed by their physician. In the case of the beneficiaries, however, a policy decision has been taken to limit to one month the supply of any one

prescribed drug and thus further prescriptions must be filled as many as 12 times per annum on the authorization of a physician. In the case of elderly persons this policy represents a determination that individuals are incompetent to follow the instructions of their physicians, to take their medications properly, and to act sensibly and responsibly.

One consequence of this policy is the fact that in 1976, the average number of prescriptions for beneficiaries under the plan was 11 and in the case of elderly the number may well have been higher. Each prescription costs the people of Ontario a dispensing fee received by a pharmacist. The data provided to the Task Force revealed that more than 40 percent of the expenditures under the Drug Benefit Plan in 1976 were incurred to pay dispensing fees. The Task Force concludes that the policy must be changed and that physicians should be able to judge the capacity of elderly persons to receive and utilize prescribed drugs for periods of 3 or 6 months or even longer. This is not merely to reduce the costs of the plan, although in our view they are excessive, but to strengthen the sense of worth and responsibility of elderly people in this important area of health care.

One further illustration of policy conflict or inadequacy may be cited. Consultants to the Task Force pointed out that the degree of lighting required by elderly persons increases significantly with the passage of each decade of life. At this time in our history however, energy conservation is an important objective of the Government of Ontario and the Task Force understands that institutions within the province have been studied with respect to their energy requirements. One consequence may be that the level of lighting will arbitrarily be reduced at the direction of one Ministry without appropriate understanding and concern for the requirements of elderly persons whose eyesight has weakened to the degree that a far greater degree of illumination is required than now exists.

The Task Force concludes that all of the policies affecting the lives of elderly people who are now beneficiaries of programs under the jurisdiction of several Ministries in the government of Ontario – notably Health, Community and Social Services and Housing – should be carefully studied and re-examined in a comprehensive policy review. Those policies which are now inappropriate should be changed. And an effort should be made to establish inter-ministerial arrangements whereby anticipated modifications of existing policy are carefully checked with relevant departments of government, to ensure that the implications of such policy changes are given full consideration in the light of the health care needs of elderly persons.

The Alternatives

The general parameters of the health care delivery system in Ontario are identical for all age groups. Since it is desirable that elderly people be treated in the same fashion as others in the population, this arrangement in Ontario is appropriate, in the view of the Task Force. Nevertheless, this is not the only system whereby health care services may be delivered to people. Although the elderly should not be considered separate, and should not be singled out for special treatment, the fact remains that there are certain different or more intensive health care requirements which, together with all other aspects of the lives of older persons, may combine to recommend serious consideration of alternative systems of service delivery.

The Task Force devoted its attention to two relatively new approaches in Ontario which, taken together, form the basis of a significant alternate health care delivery system. The recommendation of the Task Force that Placement Coordination Services (assessment and placement services) should be extended throughout the province constitutes one facet of this new approach. The further conclusions and recommendations of the Task Force that Home Care Programs should be extended to every region of the province and that chronic care be provided through such programs to persons in their own homes, constitutes the second facet of this new overall approach. Both of these recent changes in policy and procedures are discussed in substantial detail in the main report.

The significance of Placement Coordination Services rests squarely, as has already been indicated, within the requirement of many elderly persons for long term community or residential care. If we in Ontario are to provide the most appropriate care for these elderly persons, the health care needs and other requirements of such individuals must not only be carefully assessed but appropriate placement must be made on the basis of such appraisal.

At the present time all forms of institutional long-term care have been criticized because they are alleged to seek out only the least problematic and the most amenable elderly persons as residents. In brief, this means that those who are fortunate to obtain institutional residence constitute the least troublesome among the elderly or, to put it another way, those who need the accommodation least may be in the majority among the beneficiaries of such accommodation, while those who need the service most are forced to remain in whatever arrangements can be made for them by their families or friends within the general community.

Provision of long-term care for elderly persons can, in the view of the Task Force, only be implemented appropriately if the Placement Coordination Services have some power to insist that the institution accept the recommendation that a particular form of care is the best to meet the needs of the specific individual who is recommended for admission, or can direct the candidate to home care or other services as appropriate. Without some form of authority in this sense, placement coordination will be little improvement over the present hit-and-miss system.

Home Care Programs are, in the view of the Task Force, one of the most significant and promising alternatives to the present health care delivery system thus far devised. In Ontario in 1978, there are 38 Home Care Programs which offer a variety of services rendered by health professionals as well as social and homemaking services contracted by the program. So long as a person is deemed by his physician to require one or more professional services in his home, either without admission to a hospital or upon discharge from a hospital or other institution, the Home Care Program will admit the individual. The variety of services provided is impressive and the per diem per capita costs are equally impressive at a time when the Government of Ontario is attempting to reach a balanced budget, and has restrained increased expenditures within the health care and social service systems for the past three years.

The annual reports of several Home Care Programs indicate that persons 65 years of age and over constitute from three-fifths to nine-tenths of the total number of persons served through the program. At the request of the individual's physician a Home Care Program may provide the services of nurses, physiotherapists, occupational therapists, speech therapists, social workers, homemakers and other ancillary services to an individual in his own home. As far as elderly persons are concerned the availability of such services is clearly a significant opportunity to enable continued residence in one's own home and in one's own community.

It is clear, of course, that the Program can only coordinate those services which exist in the community. In some parts of Ontario it is not possible to provide the full range of services because in fact there is an insufficiency of the supply of certain health care professionals and auxiliary personnel. This fact re-inforces the conclusion of the Task Force that in a number of professions, technologies, and auxiliary services, the supply of personnel must be increased greatly within the next two decades. Only in this way can Home Care Programs develop as significant alternatives which are both socially and fiancially desirable from the point of view of the patient and the people of Ontario as taxpayers.

On October 1st, 1975, the Ministry of Health made two significant decisions which promise greater service by Home Care Programs and the possibility of a real alternative to unlimited expansion of health care facilities on one hand and institutional facilities on the other. In the first place the Ministry extended the services of physiotherapists, occupational therapists, and speech therapists to the residents of nursing homes through the Home Care Programs in the respective communities. This decision has meant a real increase in the variety of services provided for elderly persons. It must be pointed out, that in the case of the largest program as an example, the Home Care Program for Metropolitan Toronto, this has meant the employment of 20 or more physiotherapists, although such professionals serve both patients in their own homes as well as those to whom the service was extended.

The second decision made by the Ministry in late 1975 was the establishment of three pilot projects in Hamilton, Kingston, and Thunder Bay respectively, to extend home care servcies to chronic care patients in their own homes. These pilot projects were studied in the course of their first two years of operation and a report on the evaluation of chronic home care was issued by the Ministry of Health in November 1977. The Ministry reported generally in favourable terms concerning the experience to-date, but felt that a further evaluation throughout 1978 was warranted by virtue of the stabilization of the case load of chronic home care, after a very rapid increase in the number of patients following the establishment of the pilot projects some two years ago.

The Task Force has concluded that the establishment and extension of home care services throughout the province, and the extended availability of chronic home care on the part of all home care programs, are warranted. Service-oriented programs are surely to be preferred to the utilization of acute care and chronic care facilities both on social and financial grounds.

They are much to be preferred, in the view of the Task Force, as decent, humane efforts to meet human needs as against attempts to discourage utilization of services and facilities through deterrent fees. The first course of action constitutes an assurance to elderly people that they are members of a community who deserve to be treated with dignity and respect, and offered some choice in their destiny. Those proposals which suggest that services would more properly be rationed through the application of deterrent fees, indicate that elderly persons are irresponsible and wasteful, and should be forced to pay from their scarce resources to meet needs which are the consequence of a normal process of biological aging.

The Governmental Organization

The health care needs of older persons in Ontario do not fit neatly into the patterns and packages of governmental organization in the province. Elderly persons have physical, emotional, social, and a host of other requirements, all of which bear upon their requirement for health and social services. Despite the commendable efforts of the Ministries of Health, Community and Social Services, and Housing, there is evidence of a serious lack of coordination within governmental organization which, if remedied, would mean a more effective system of delivery of health care services. It would also mean a more satisfied group of elderly persons and their families, and in all probability, a stabilization of cost if not a reduction in health and welfare expenditures devoted to the maintenance of the elderly in our society.

In the view of the Task Force the Government of Ontario must give significant attention, and consider as a matter of urgency, the development of a governmental organization with responsibility for coordination on an inter-ministerial basis. The recommendation that the government create a special agency, detached from direct responsibility to any one Ministry, but charged with the responsibility of coordinating the services to the elderly across several Ministries, is a matter of high priority and great significance. Coincident with the recommendation for a special provincial agency, the Task Force has concluded that regional offices should be developed within the regional municipalities in Ontario and in other localities, where appropriate. If these recommendations are accepted within the province, there should develop a combination of centralized and decentralized coordination. In conjunction with placement coordination services and home care programs, this can only result in a more effective system of identification and treatment of needs among a group who will soon represent one-fifth of the population of the province of Ontario.

Major Conclusions

The most significant determinations of the Task Force are encompassed within the concepts of (a) coordination, (b) re-organization of health care delivery, (c) service requirements and (d) requirements for residential facilities. Major recommendations have been made in these areas of concern as well as with respect to the education of health care professionals, the need for research in geriatrics and gerontology, and the relationships between the Ministry of Health and other Ministries in Ontario which play important roles in meeting certain specific needs of elderly persons and provide programs which, in our view, require improvement.

Concern for coordination of services and facilities arises from the obvious fact that the programs designed to assist elderly persons to maintain health and well-being, and to provide care when they can no longer maintain independence in the community, do not fall within the responsibilities of any one Ministry or agency in the Government of Ontario. Moreover, there is evidence of lack of planning in most communities, overlapping services, confusion with respect to responsibilities as between the local, regional and provincial governments, and inappropriate use of facilities in the absence of functional integration among institutional facilities. Accordingly, we have recommended:

THAT the Ministry of Health, in cooperation with the Ministry of Community and Social Services, establish Placement Coordination Services, with relationships to District Health Councils and municipal governments, for each area, district or region of the Province, to achieve the following purposes:

- To act as a knowledgeable focal point to permit advanced planning for any move from home to institution or between institutions;
- To coordinate the care of the elderly persons and ensure that people are placed in the best level of care and location to suit their needs;
- To avoid unnecessary or premature institutionalization by ensuring that all community resources have been considered;
- To ensure that a patient is moved through levels of care, with ease and at the appropriate times;
- To ensure that no person is discharged from any institution until the family or other organization has had adequate time to prepare for the discharge. (ref. p. 77)

THAT the Minister of Health impress upon the Government of Ontario the urgent need to develop a new coordinating mechanism for services for the elderly, perhaps reporting to the Provincial Secretary for Social Development, with at least the following direct functions:

(1) To identify the requirements for health, social, housing, educational and recreational services throughout the province;

(2) To coordinate all regional (local) health and social service programs provided for the elderly;

(3) To establish standards and evaluate such health and social service programs;

(4) To provide consultation and support services for offices at the regional or district health council level. (ref. p. 80)

Governmental organization for health care delivery to older persons in Ontario is by no means inadequate. It is, however, adjusting very slowly to the inevitable gross impact of a doubling of the population 65 years of age and over within the next quarter-century. Moreover, it remains strongly reliant upon acute care hospitals and institutional facilities which are enormously expensive. The Task Force holds strongly to the view that the answers to the twin problems of substantial increases in demand and inordinate cost rest, in addition to Placement Coordination Services, in a firm resolve to maintain persons in their own homes and in their own communities as far as possible. The Task Force recommends, therefore:

> THAT the Ministry of Health expand Home Care Programs to provide better total care in elderly persons' own homes, in order to prevent unnecessary institutionalization. (ref. p. 70)
>
> THAT the Ministry of Health make Home Care Programs more accessible for people in need of long term care, on the assumption that the further evaluation of the pilot projects offering home care to chronic patients in Hamilton, Kingston and Thunder Bay, supports the expansion of Chronic Home Care. (ref. p. 70)
>
> THAT the Ministries of Health and Community and Social Services jointly assess the problem of providing home care in rural areas and take appropriate action. (ref. p. 70)

There are already unmet requirements for health and social services for the elderly and urgency in planning and implementing programs to meet clear deficiencies. These include current and future shortages of professional and para-professional personnel, insufficiencies in the volume of direct services, and barriers of cost to the acquisition by elderly persons of urgently required health services and appliances. We have, therefore recommended:

> THAT the Health Manpower Planning Section of the Ontario Ministry of Health continue and strengthen its effort, with the advice and assistance of the Human Resources Committee, Ontario Council of Health, to establish the balance or imbalance between supply and demand and to encourage proper distribution among the health care professionals required to serve elderly persons over the next three decades; and to develop health manpower plans to meet estimated staffing requirements. (ref. p. 59)
>
> THAT the Minister of Health request the Minister of Colleges and Universities to encourage an increase in the number of audiologists and support staff trained to deal with the increasing frequency of deafness in the population. (ref p. 45)
>
> THAT the previous recommendations of the Ontario Council of Health, in Council's Report on Chiropodists in Ontario, 1973, be implemented; and

THAT the Minister of Health request the Minister of Colleges and Universities to take steps to increase the number of chiropodists available in the Province by the establishment of educational programs in the Colleges of Applied Arts and Technology. (ref. p. 55)

That the Minsiter of Health request the Minister of Community and Social Services and Minister of Colleges and Universities to encourage the Colleges of Applied Arts and Technology to strengthen and/or develop courses designed to train students such as social service aides and heath care aides to work with elderly people who require assistance to maintain residence in their own homes in the community. (ref. p. 88)

The Task Force in convinced that health disabilities and consequent significant cost to the health care system result from cost barriers which induce many elderly people to neglect such areas as dental care, care of hearing and care of eyesight. We have, therefore, recommended:

THAT the Ministry of Health give consideration to the payment of all or part of the cost of certain major dental procedures and prostheses for the elderly, eligibility to be determined on the basis of need. (ref. p. 43)

THAT the Ministry of Health give consideration to the payment of all or part of the cost of hearing aids for the elderly, eligibility to be determined on the basis of need. (ref. p. 45)

THAT the Ministry of Health give consideration to the payment of all or part of the cost of eyeglasses for the elderly, eligibility to be determined on the basis of need. (ref. p. 48)

Although the Task Force is dedicated to the proposition that elderly persons, so long as they are able, should remain in their own homes within their own communities, it recognizes that institutional residence will be the most appropriate living arrangement for some people. The need for nursing homes, chronic care facilities and homes for the aged appears already to exceed the available supply of beds. We are most concerned, however, about the apparent absence of long range planning, for the time 15 or 20 years hence, when the number of required residential accommodations threatens to be overwhelming. Accordingly, the Task Force has recommended:

THAT the Ministry of Health undertake a study of the current supply and probable requirements for chronic hospital and nursing home beds, by five-year periods during the balance of the century, and develop plans to provide required institutional facilities through new private construction, expansion of existing homes and appropriate conversion of existing buildings in the community to such uses; and (ref. p. 59)

THAT the Ministry of Health request the Ministry of Community and Social Services, perhaps jointly with the study of chronic hospitals and

nursing homes, to undertake a study of the current supply and probable requirements for beds in homes for the aged, by five-year periods during the balance of the century, and develop plans to provide such institutional facilities as are required in appropriate locations. (ref. p. 60)

There are substantial and numerous recommendations throughout the main body of the Report of the Task Force. All recommendations, including those presented in this summary chapter, will be found in Appendix C.

It is not easy to recommend new and expanded health and social services and residential facilities at this time in the economic history of Ontario. These conclusions and recommendations are made with a clear conviction of their necessity and desirability, and with the further understanding that there is not ever really a "good" time to insist upon further expenditures. The Task Force firmly believes that the people of Ontario will pay more for neglect of essential services for the elderly than they will for decent and adequate provisions. Moreover, adoption of the recommendations concerning Placement Coordination Services and Home Care Programs may well re-distribute sufficient income within the health care system in Ontario to meet a substantial proportion of the new and expanded requirements.

Chapter 1:
Aging in Canadian Society:
Normal Progression or Social Problem?

A) The Facts of Aging

Aging is a natural process, commencing at conception and ending with death. The greatest strains in the process are during the early years and toward the conclusion of life. The process does not proceed at the same rate from person to person, with the result that certain general social policies may be subject to serious question. Many professional practices may also be based upon a perception of identical health status at certain stages in the life cycle.

Retirement policies based upon a fixed chronological event, such as reaching age 65, are an example of socio-economic policies that may be potentially harmful to the individual. The matter of a fixed retirement age is under consideration, and compulsory retirement may be eliminated.

In the practice of several professions the notion of 'normal' is a matter of serious consequence to persons who have reported time and again that their concerns in the field of health were met by a question relating to their specific age, followed by a statement of expectation relative to that specific age; in short, their problems were treated by professionals as primarily age-related, rather than person-related.

Available demographic projections of the future population by age groups constitute the framework within which health care services must be provided. One very simple way of looking at the basic numerical data is presented in the following tabulation:

Table 1: Present and future proportions of Canadian population beyond specific ages

	Present (1971)	Estimated Future (2001)
Over 60 years	1:8 (12½%)	1:5 (20%)
Over 65 years	1:12 (8½%)	1:9 (11%)
Over 70 years	1:20 (5%)	1:13 (7½%)

Source: Census of 1971 for the Present; *Population Projections for Canada and the Provinces, 1972-2001,* Statistics Canada, Catalogue #91-514 (Ottawa, Information Canada, June 1974) passim.

Estimates are made on the basis of future rates of fertility, mortality and migration. A conservative projection indicates, for the nation as a whole, the number and proportion of Canada's population aged 65 and over, at 10-year intervals during the next half-century.

Table 2: Canada's population 65 years and over 1971-2031 ("Projection B.")

Year	Population 65+	Percent of Total Population
1971	1,744,400	8.1
1981	2,272,300	9.3
1991	2,916,000	10.5
2001	3,341,800	10.9
2011	3,793,800	11.4
2021	4,984,500	13.9
2031	6,142,700	16.1

Source: "Health Services for the Elderly", *Final Report of a Working Group of the Federal-Provincial Advisory Committee on Community Health* (Ottawa, Health and Welfare Canada, August 1976) Appendix B, p.8.

Projection B: Fertility Rate 2.2, Immigration 60,000, Interprovincial Migration 435,000.

The total numbers are only one aspect of the situation; further aspects include breakdowns for specific five-year age groups and the distribution by sex. The following table provides a reasonable projection for males and females and the total population for the province for the balance of the century.

Table 3: Population projects for Ontario (1971-2001)

TOTAL	1971	1981	1991	2001
65-69	227,800	297,000	388,800	394,600
70-74	171,500	221,900	280,700	341,700
75-79	121,000	158,400	210,600	276,700
80-84	74,400	96,300	128,900	164,600
85-89	35,900	47,200	67,700	91,000
90+	13,900	19,400	32,900	47,200
TOTAL	644,500	840,200	1,109,600	1,315,800
MALE				
65-69	106,100	137,000	172,800	178,900
70-74	74,400	97,100	117,800	145,300
75-79	48,900	63,400	82,000	103,300
80-84	28,200	34,300	45,100	54,700
85-89	12,900	14,800	19,700	25,500
90+	4,400	5,400	7,100	9,500
FEMALE				
65-69	121,700	160,000	216,000	215,700
70-74	97,100	124,800	162,900	196,400
75-79	72,100	95,000	128,600	173,400
80-84	46,200	62,000	83,800	109,900
85-89	23,000	32,400	48,000	65,500
90+	9,500	14,000	25,800	37,700

Source: 1971 data from Statistics Canada *Population 1921-1971*, Catalogue 91-512 Occasional, July 1973; for later years, *Population Projections for Canada and the Provinces* 1972-2001 (Canada Statistics Catalogue 91-514), Ottawa. Information Canada, June 1974, pp. 119-133 (Projection B).

Table III provides three important sets of data which are of fundamental importance in planning for the delivery of health and related social services to older people in Ontario. In the first place, it is clear that the *total number* of persons aged 65 and over will be nearly double the current figure (approximately 730,000 in 1976) by the end of this century. It has already been indicated that the *proportion* of persons 65 and over will be significantly greater as well, by virtue of the rapidly declining birth rate evident throughout Canada since about 1960 and a slowly declining mortality among Canadians, especially among women.

The second aspect of the data concerns the changing age structure of the older population of Ontario. In brief, the number of persons who will be between 75 and 79 years of age and in the age groups over 80 will increase proportionately at a faster rate than those in the younger groups among the older population, that is those 65-69 and 70-74 respectively. For example, those persons aged 65-69 in Ontario will increase between now (1976) and the end of the century by 54.4 percent; those between the ages of 80 and 84 will increase by 97.1 percent; and those who are 90+ years will increase by 191.3 percent.

The third aspect of these data concerns the male-female distribution among older people in Ontario. It is anticipated that not only will the total *number* of females among older Ontarians increase substantially more that older males, but in every age group the *percentage* increase among females is projected as greater than among males. As a consequence, the percentage of females in the total elderly population will become even greater than it has in the past while the percentage of males will decline. This finding is contrary to the expectations of some observers who have considered that increasing participation of women in the labour force and the increasing use of alcohol and tobacco by females have already led to an increased incidence of certain illnesses now more characteristic of males in the population, and thus to a higher death rate among females.

The projected picture of the older Ontario population some 25 years hence is thus the following: far greater in numbers, far older in general in the sense that those who are "old-old" will be an increasing percentage among all those over the age of 65, and far more female in composition than at the present time. The implications of these projections for the delivery of health care some two decades from now, and during the intervening period, are quite significant, not merely in terms of the volume of services which will inevitably be required but in terms of the provision of professional manpower. In addition, there is the possibility of additional physical requirements (facilities) and the requisite financial obligations in both capital and operating terms.

The Task Force took as its position on demographic projections, that it would accept these data as reasonable working propositions. It is known that there are other possible population projections under different assumptions concerning mortality rates, fertility rates, net migration to Canada and thus to Ontario, and interprovincial migration. Nevertheless, it concluded that there was no value in disputing projections in order to add or subtract a few thousand persons from the total or within specific age groups. Projections will need to be updated from time to time. How-

ever the situation, in general terms, will be unlikely to change significantly from the projections presented in Table III for the Province of Ontario.

Recent trends in unemployment and economic conditions generally, coupled with media attention to the increasing number and proportion of elderly persons in our society, have raised the prospect of conflict between the generations, the possibility of inadequate funding of public and private pension schemes, and proposals for certain services. There is a danger of the elderly losing the benefits they already have in a competition for scarce resources. The Task Force wishes that government were constrained to continue and strengthen its programs.

After careful consideration of these concerns and the demographic projections and their implications for health and social services in Ontario, the Task Force recommends:

Recommendation 1. *THAT the Government of Ontario enunciate its awareness of the increasing number and proportion of persons aged 65 and over to be expected by the end of the century and beyond, and despite existing financial constraints, emphasize its commitment to provide adequate and appropriate health care and social and income maintenance services for the elderly.*

B) The "Health Field Concept"* and the Aged

It is not really known whether the number of years a person remains well will increase on the average. The general consensus is, however, that while total life expectancy may not increase markedly in the future, there will be an increase in the years of "healthy life". Health care cannot be considered in isolation but must be viewed in relation to the overall socio-economic and political environment with which it inter-relates. The state of health of elderly people is, in large part, predetermined by their lifestyles and habits in early childhood.

The "Health Field Concept" will provide a suitable system of classification in which to view the totality of the environment. The so-called "health field" is broken up into four broad elements: Human Biology, Environment, Lifestyle and Health Care Organization.

1) *Human Biology* (including all those aspects of health developed within the human body)

*Government of Canada, Health and Welfare Canada, *A New Perspective on the Health of Canadians,* issued by the Honourable Marc LaLonde, 1974, pp. 31-34.

It will be necessary to add to the knowledge of human biology by more research, particularly in the areas of genetic inheritance, the process of maturation and aging and the many complex internal systems of the body. Further study of the effects of transplant and the immune response may be important.

Political decisions will undoubtedly determine whether money will be allotted to such research. There is somewhat more research in geriatrics (medical practice with the aged) than in gerontology (aging in the broadest sense), but research initiative in both these areas in Canada continues to be sparse. If we fail to create the proper environment, people will not be encouraged to enter the field of research on aging or the health problems of the aged, nor professional service with older persons.

The Task Force noted that the Committee on Health Research and Development* of the Ontario Council of Health has identified cell biology and genetics among other fields, as areas of high priority for research and has recommended that these fields of research be supported on the basis of programmatic proposals from groups of established investigators. The Committee has also recommended that personnel support be provided to train new investigators and create career positions to enable recruitment of able scientists. In addition, it proposed that contract mechanisms be used for health research of high priority to government and in terms of public need. We support the proposals of the Committee on Health Research and Development, and within the overall provincial health research priorities, the Task Force recommends:

Recommendation 2. *THAT the Government of Ontario in its research funding through the Ministries of Health and Community and Social Services, assign greater priority to studies of the elderly and pre-elderly population; and*

THAT all granting agencies encourage scientists to direct more research effort to the process of aging, particularly in the following areas:

- *Genetic aspects of aging;*
- *Illness associated with age;*
- *Specific effects of aging on the health of special population groups.*

**Health Research Priorities for Ontario,* Ontario Council of Health, 1977, pp. 3 and 5.

2) *Environment* (including all those matters related to health which are external to the human body and over which the individual may have little or no control)

a) **Physical Environment**

There will be need in future for greater control of the quality of air, water, food, soil and noise pollution. There should be a reduction in the untoward effects of radiation, tobacco smoking (i.e. other people's), communicable diseases, drugs, cosmetics, garbage and sewage and adverse environmental working conditions.

There must be further development of technology, relative to the availability and utilization of energy, with concomittant restrictions on consumption. More initiatives must be developed in housing (flexibility), transportation (accessibility) and education (opportunity) to meet the needs of the elderly population as well as the handicapped.

Further study of the effects of migration as it relates to our aging population is required. Very little attention has been paid to the difference between aging and the incidence of disease among newcomers to Canada by comparison with the native-born; moreover the impact of inter-provincial migration has not been studied insofar as elderly persons are concerned.

b) **Social Environment**

The possibility of inter-generational conflicts must be considered. This may be related in substantial measure to an examination of aging among newcomers to Canada but is not restricted to conflicts between generations affected by major transformations in culture. As far as the nation as a whole is concerned, such conflicts will be related to the availability of energy, food and shelter – a shortage of which may change societal attitudes toward death and dying. Moreover, attitudes may change particularly in respect to the elderly, the mentally retarded and the handicapped.

Greater independence of the elderly must be encouraged by means of assuring adequate income, community services with ready access, structural changes in living accommodation and assistance to relatives who are maintaining the elderly in their homes. Financially there may have to be changes in pensions and in the age of retirement. The costs of services to the elderly may have to be related – up to a point – to their ability to pay.

Due to the high cost of delivery of health care, it will be necessary to encourage many more volunteers in this field, including elderly persons themselves.

3) *Lifestyle* (consisting of the aggregation of decisions by individuals which affect their health and over which they have more or less control)

There will be social emphasis on the prevention of illness and moderating self-imposed risks such as alcoholism, drug abuse, poor diet, obesity, poor driving habits and non-use of seat belts, poor work habits and working conditions, self-imposed social and economic stresses and the like. A great deal of public education of a preventive nature should begin in early childhood.

Alcoholism tends to increase in the elderly who were regular drinkers in middle age; there appear to be few proven cases of 'brand new' alcoholics in institutions. Thus consideration will have to be given to allowing moderate drinking in institutions, perhaps through the establishment of an area to be used as a social lounge, rather than the continuation of present demeaning practices.

4) *Health Care Organization* (consisting of health care delivery)

There will be a greater demand for health services because of the greater utilization of these services by the larger numbers of the elderly in the population. This can only mean that there must be a greater emphasis toward promotion of good health and the prevention of disease.

There already has been a slight shift from institutional to non-institutional care, at least for those age groups below the mid-eighties, whereas institutional care for the group 85+ will probably increase. Great emphasis will be placed on the expansion of the present programs, and further development of new alternatives, or a complementary system to institutional care will be required. Since the present system is weighed toward institutionalization, some people are admitted to institutions who do not need to be there. There should be a mechanism to identify the needs of individual elderly people so that they can be met in the best way. These changes do not necessarily come under the aegis of the Ministry of Health; they may add more responsibility to other Ministries, particularly to Community and Social Services.

The physician-centred health care system may have to be modified. The model may, rather, shift from a strictly medical-nursing model

to include psycho-social components to a much greater degree. These changes will be accompanied by pressure to make health services more accessible and more comprehensive.

At the same time the education of physicians and allied health personnel will have to become more concerned with the care of the elderly. As well, effective information systems for evaluating and planning health care will have to be developed, as will co-ordination services for proper placement of patients in institutions or agencies.

There may be a gradual decentralization of the responsibilities for health care delivery. In Ontario, twenty-one district health councils have been established, with responsibility for planning health services for their area. Even though, at the present time, they are advisory bodies to the Ministry of Health and do not have executive authority, a good many of the councils have been able to influence significantly the health care system at the district level. Several district health councils have set up special committees to consider the needs of the elderly, their care and appropriate placement (e.g. committees on aging, long term care committees).

Health legislation in general may become more mandatory than permissive. In this regard it will be important to anticipate the "ripple effect" of the unforeseen outcome of proposed legislation, meaning individual rights may be over-ridden by societal rights.

The Task Force concluded that future health care must be the product of all various components concerned in the "Health Field Concept" – all functioning interdependently and mutually supportive.

C) Health Services for the Elderly

In the normal course of events, older persons obtain health services in Ontario in exactly the same way as the rest of the population. A person has his* own general practitioner and dentist and health care is delivered in the customary private practitioner/patient relationship. Some persons may not have their own physicians and may therefore attend a family practice clinic in the community or in an acute care hospital.

It is a fact, however, that persons over age 65 do consult physicians more frequently than the general population and older persons utilize acute hospital beds more intensively than the general population. Recent estimates indicate than Ontarians over age 65, representing only 8.56

* Wherever the words "his" and "he" appear in this report, they should be read as "his or her" and "he or she".

percent of the population, utilize 16.2 percent of all medical services rendered in a specific year, and similarly utilize 33.27 percent of all acute hospital bed days (excluding psychiatric units) in a typical year.* As the number and proportion of older persons in the population increases during the next two decades it is likely that the utilization of all available health care services by older persons will increase dramatically. The implications would seem to be that either the competition for available services between those over and under age 65 will intensify, or the Government of Ontario will have to develop additional health care facilities and services to meet a substantially increased demand.

The roster of services available for older persons includes among professional medical practitioners, the services of family physicians, general practitioners, internists, family practice clinics and the like. The length of time required by physicians to examine their elderly patients is considerably greater than required for younger people, and the Task Force recommends:

Recommendation 3. *THAT the Ontario Medical Association consider negotiating a differential fee for OHIP payment to physicians for a multi-system assessment and complete examination of the elderly, because of the greater time that is required than for younger patients.*

In the case of a serious illness requiring hospitalization, an older person is more likely than a younger person to proceed from an acute care hospital to convalescent or long term care facilities. If such a person is unable to return to his own home or community he may require residential care in a nursing home provided by a private entrepreneur licensed by the Province of Ontario or in a home for the elderly operated by local municipalities, counties or regional governments and some voluntary organizations in the larger urban centres. Alternatively, elderly individuals may be able to remain in their own homes or communities with the assistance of home care services available in a number of Ontario cities or through the utilization of day hospitals or day care facilities offered through public or voluntary organizations including homes for the elderly operated in the private sector.

Elderly persons in Ontario customarily have a great variety of members of professional disciplines to draw upon for health care and related services. Physicians have already been mentioned. As is the case with the

*Estimates were provided by the Data Department and Evaluation Branch, Ontario Ministry of Health. Medical services utilization for fiscal year 1976/77; hospital utilization for 1976 (File R-29); TEIGA 1976 estimates.

general population, some elderly people require services of dentists, pharmacists, nurses, physio- or occupational therapists, social workers, nutritionists, chiropodists, counsellors derived from various professional backgrounds, including members of the clergy.

There is at present nothing particularly different about the manner in which health care services are delivered to older people than is true of the population as a whole, other than the fact that the requirements of the elderly for the services of particular professional persons may be greater than the rate of utilization by the general population. For example, persons 65 or older may utilize a greater proportion of the services of physiotherapists and chiropodists by virtue of the particular problems which afflict older persons than would be true of the general population. In the case of specific social and community services, older persons may require a greater portion of the available time of visiting homemakers or nurses involved in the provision of home care services than is true of the population as a whole.

A major difference in the provision of medical and hospital services for the elderly lies not in the method of delivery or receipt of care, but in the financial arrangements whereby health care is made available. In the Province of Ontario, the Ontario Health Insurance Plan (O.H.I.P.) provides medical services and standard ward care in hospitals together with a variety of attendant services, without direct premium payments by the recipients. Moreover, Ontario provides, without direct personal payment, a substantial list of drugs required by elderly persons, when prescribed by their physicians or dentists. Not every drug is on this list but a significant proportion of the requirements of older persons does not involve a direct expenditure. In the case of dental services, however, persons over age 65 are quite unlikely to be covered by any dental plan in which they may have participated prior to retirement and must pay the usual professional fee. These costs may indeed be a significant deterrent to the attainment of adequate dental care including preventive services. Moreover, dental services are not characteristically offered to elderly persons in outpatient clinics or dental school clinics.

Chapter 2:
Health Care – Needs and Requirements of the Elderly

Although the Task Force adopted a normative approach to the process of aging, it recognized that this did not mean that the health care needs of every element in the age distribution of the population were identical. Nor did it mean that each individual exhibited, at particular age levels, exactly the same pattern of illness or well-being as another person at the same age level. The normative assumption required two clear exceptions: in the first place, there are distinctly different health care needs of the aged; and, secondly, a specific age designation tells little or nothing of the particular situation of the individual person with respect to his health care needs.

A) The Distinctly Different Health Care Needs of the Elderly

Some persons over 65 years of age are distinguished by increasing frailty and diminished tolerance of stress as their lives proceed. Moreover, they do experience different patterns of disease than do younger persons. Old age is also a time for losses – losses of spouse, family, friends, security, health, strength and sense of worth. All of these experiences contribute to a loss of the sense of well-being or to illness and may be causally related as well.

Throughout adult life, structural changes occur in tissues and organs progressively with time. There is also a decline in physiological function. These changes vary between individuals and functional decline does not correlate accurately with the structural changes. Stresses can include environmental condition, psychological and social problems, illness and both medical and surgical therapy. Our society should provide protection and encouragement to the frail, an environment in which they can continue to be socially active and valued.

Patterns of disease in older people involve in the first instance the notion of 'chronicity'. Many diseases become apparent in late life but begin much earlier. It is important to emphasize the distinction between the "normal processes of time" and "disease". Nevertheless, even if disease is acute in its clinical onset, it may be essentially a chronic illness and unlikely to be curable. Treatment may not cure but can alleviate pain and disability. The likelihood of recurrence implies the necessity of ongoing follow-up. It was noted that about seventy percent of those over

age 65 do have a chronic illness but only twenty percent consider themselves unwell.*

A second element in a consideration of different patterns of disease is encompassed within the notion of 'complexity'. Several chronic diseases are likely to be present in one person and the number and severity increase with age. Treatment of one disease may make another worse (e.g. bed rest for myocardial infarction may result in contracted joints and muscle wasting). Careful investigation should be made to obtain accurate diagnosis without excessive discomfort to the patient and then a wise judgment must be exercised as to how far to carry therapy. Response to treatment may be slow.

A chronic disease may be far advanced before becoming manifest but in the aged even acute disease may not show such classical signs as fever or pain. For this reason alone all health professionals should have training in geriatric care with specialists available for further consultation.

Elderly people may be reluctant to admit to illness and much illness may not be reported. They and their families may wrongly attribute symptoms to the process of aging and assume that nothing can be done. In this view they are often encouraged by health professionals who imply that expectations of certain illnesses must be accepted at specific age levels. On the other hand, despite many chronic illnesses, most older people consider themselves well and a health examination must not, by identifying disease, convert a feeling of wellness to a feeling of illness. Nevertheless, it is important that the health status of these patients be monitored. The Task Force therefore recommends:

Recommendation 4. *THAT the College of Physicians and Surgeons of Ontario urge physicians, in association with other health professionals, to develop a plan with their elderly patients to ensure that their treatment needs are periodically assessed, that appropriate therapy is provided and that follow-up is arranged.*

The matter of what is appropriate or should be expected in old age extends to the question of mental condition. Depression in old age is often missed, perhaps because it seems appropriate to the observer, and suicide is not uncommon.**

Since most older people feel well and are indeed reasonably well, they

*E. Shanas et al: *Old People in Three Industrial Societies*, New York, Atherton Press, 1968.

**I. M. Sendbuehler, "Suicide and Attempted Suicide Among the Aged", *Canadian Medical Association Journal*, Vol. 117, No. 5, September 3, 1977, pp. 418-419.

wish to remain in the community. In order to do so they need support, encouragement, services in the home, supervision and information. Our health care system, generally oriented toward technological and acute care, meets only some of these needs. In light of this discussion, the Task Force recommends:

Recommendation 5. *THAT the Ministry of Health, district health councils and health professionals emphasize community and on-going care and effect a shift from the present technological and acute care orientation of health services.*

To attain these goals, appropriately trained professionals and a well-informed public are prerequisites. (See also Chapter 4, pp. 84-94)

B) The Medical Problems of the Elderly

For each person there comes a time in life which is accompanied by decreasing mental and physical functions which, when minimal, are accepted. Decline can be very gradual and level off at a comfortable plateau for many useful years. The illnesses which the aged most often suffer are:

Physical Illness:	Skin changes
	Eye problems
	Hearing problems
	Chest problems
	Heart problems
	Cardiovascular disease
	Hypertension
	Strokes
	Gastrointestinal problems
	Malnutrition (or poor nutrition)
	Obesity
	Tumors
	Diabetes
	Genito-urinary problems
	Bone and joint problems
	Osteoporosis
Mental Illness:	Depressions
	Psychoses
	Senile Dementia

The Task Force understands that skin changes, chest problems, cardiovascular disease, hypertension, peptic ulcers, tumors, diabetes, genito-

urinary problems and depression can be adequately diagnosed and well treated by physicians, provided they take the necessary time and are motivated to make a careful examination.

Decreased hearing is a common problem in aging and it is a question whether all who can be helped by hearing aids are availing themselves of that help. It is also a concern of the Task Force whether some of the changes which lead to poor hearing can be prevented. There is a further problem that people often do not realize they are going deaf and tend to withdraw into themselves. (See also Chapter 3).

It is clear that no resident of the Province of Ontario should suffer from malnutrition when it is evident that there is an abundance of necessities available. Education of the subject of nutrition is important, and such community resources as Meals-on-Wheels are valuable. Poor nutrition is found among some elderly persons and yet, obesity is a health problem in the aged.

While treatment of women and men for genito-urinary problems is generally good, it was felt that inquiries should be made of urologists concerning present and projected needs related to prostatism. It is not known whether research is being undertaken into prevention of such problems.

Many changes in joints can be minor and are either tolerated or treated by the patient, his family or friends, without medical guidance; while most people are uncomfortable periodically, they can be at ease much of the time. Severe joint diseases, particularly of the knee and hip, are being treated more and more by sophisticated surgery at considerable costs. The incidence of broken hips in enormous and the Task Force learned that it is possible the fall is caused by the hip breaking (because of osteoporosis) rather than the other way around – that is, the hip breaking because of the fall. However, there is insufficient information in this respect. The Task Force therefore recommends:

Recommendation 6. *THAT the Ministry of Health commission an epidemiological study to determine the common causes of accidents among the elderly and thus to suggest measures of prevention, since hip fractures, for example, are a major cause of the institutionalization of elderly people.*

The field of rehabilitation of the aged (see also Chapter 3) is considered to be inadequate in terms of province-wide facilities and services but it should be an exciting challenge to physiatrists, physiotherapists, occupa-

tional and speech therapists, to help old people make the best of what they have left after a stroke, a broken bone and so on. It is acknowledged that the rewards for the professionals and the patients are slow and those who are helped may not return to full activity. However, return to partial activity may allow the patient to function at a satisfactory level.

On the subject of mental illness, the Task Force felt that senility is not as widespread as many people assume. Old people are often judged too quickly. The reactions of every person are based largely on experience and familiarity – in emergency situations, for example, a person may often act irrationally. When an elderly person is moved suddenly from his familiar environment to a strange environment, it is an upheaval which can be very upsetting, and the person does not at first react well. His condition should therefore be noted at this initial stage, but judgment on his mental condition should be made at a later date when he has had time to become accustomed to new surroundings and a new regimen. It is therefore preferable to avoid relocation of very old people or those who have developed impairment of memory. However, if relocation must be made, the old person may be able to readjust after a period of time if closely supported and supervised during the adjustment period.

In discussing ways of assisting elderly persons in the community to maintain their health through regular visits by a responsible person, perhaps combined with a "safety check" to recommend methods of preventing falls and simply to talk with the elderly person to see what can be done to assist him, the Task Force concluded that public health or community nurses might well exercise the monitoring function, but that the visitor need not be a nurse. However, a person with some "official status" is needed to allay the fears of elderly people and to be welcomed into their homes. As far as the use of drugs is concerned, the Task Force found in discussion with a group of elderly people, that the latter had respect for medication and were aware of its dangers. They said they used their own judgement, tending to take less medication than was prescribed for them rather than more.

The medical management of the elderly is compounded by several clinical problems. These include confusion, falling, decreased mobility and incontinence. These situations, together with mental and physical illnesses which have been carefully identified, have significant implications for meeting the health care needs of the aged. Rehabilitation services, nutritional education and counselling are some aspects of a multi-faceted situation. The whole question of prevention of health problems among

older people has received relatively little study in the view of the Task Force. Moreover, there is the additional question of the maintenance of the condition of elderly people after illness or some problem has been experienced and treatment has been undertaken.

In recognizing these problems, the Task Force would suggest that the Ministry of Health devote more study and attention to the prevention of health problems among older people. In addition, more educational and counselling services should be provided to older people and their families.

C) Differential Health Care Needs of the Young-, Middle- and Old-Old

The use of a fixed age as indicating that a person is elderly and eligible for certain benefits or retirement has become customary. Within the Government of Ontario and by virtue of certain inter-governmental programs, however, different ministries have utilized different age levels in the administration of specific programs. For example, certain income maintenance programs administered by the Ministry of Community and Social Services are available to persons who are aged 60; the Ontario Housing Corporation considers a person aged 60 years or over to be eligible for senior citizens' housing. Most frequently, however, the date at which people are considered elderly is age 65, by virtue of its applicability to the date of retirement of the great majority of persons in the labour force.

In the case of health care it is not only misleading and inaccurate but potentially dangerous to generalize about the elderly, whether we use a dividing line between middle and old age at 60, 65, 70 or even later years. Older people become increasingly different from one another psychologically and in their personalities. This is partly due to an ever-wider variety of experiences as time goes on. Similarly with physical changes – there is a tremendous individual variation in rates of aging and the onset of illness and disability. Elderly Canadians are a heterogeneous group with a variety of lifestyles and needs. They frequently differ from one another more than they do from the young and even more than the young do from each other.

In spite of these differences, some generalizations can be and must be made about the elderly in order that we can deal with their problems and make plans for the future. In addition to individual differences, we must keep in mind significant differences between various demographic subgroups of the elderly, such as men and women, rich and poor, urban and rural, young-old and old-old. The differences between the last two

groups have been emphasized increasingly in recent research and publications. The Federal-Provincial Task Force on Health Services for the Elderly, cited earlier, stated: "The young-old and the old-old exhibit a change and an increase in their needs for health and social services".*

It is increasingly recognized that Canadians 65 to 74 years of age are, as a whole, relatively problem free. The majority are still married, friends of the same age are living, they are in relatively good health and are managing reasonably well economically because of two or more pensions. After age 75, the problems of ill health, widowhood, loneliness, poverty and so on are all fairly generally on the increase and similarly with the need for health and social services. As age increases, the need for and the prospect of institutionalization increases. Data from the United States and the United Kingdom indicate that those past 75 are about three times as likely to be residing in an institution as those in the age group 65-74.

The increases in the health care needs of those aged 85 and over are naturally even greater than in the group aged 75-84. In the United States, for example, the proportion of institutionalization among those 85+ is double that of the group 75+. Because of these factors, that is the changes which occur as people become one or two decades past the commonly considered retirement age of 65, the following divisions and names have been suggested for the demographic sub-groups of the elderly:

TABLE IV

SUB-CATEGORIES OF THE AGED

Age Group	Designation
65-74	Young-Old
75-84	Middle-Old
85+	Old-Old

The two older sub-groups are frequently combined into one group, that is 75+, described as old-old. This group is given top priority in assessing present and future institutional and community needs and services for the elderly.

The implications of differentiating between the Young-Old and the Old-Old are clear and significant. Planning for these enormous increases must begin now. Ontario must be prepared for the particularly rapid increase

**op.cit.*, p. 9

of the Old-Old by the end of the century and into the twenty-first century (estimated at 156 percent) when the longer lived "baby boom" generation (those born between 1944 and 1961) with their fewer children arrive at the period of old age. The planning, of course, must take into consideration the differential requirements of the Old-Old, including particularly the special forms of residential care required in far greater supply than now exists. Increasing frailty and the multiplicity of chronic illnesses mentioned previously will inevitably reach a large group of the surviving population.

D) Special Problems in the Delivery of Health Services

In Ontario, hospitals fall into three main categories – acute treatment; convalescent and rehabilitation hospitals; and chronic hospitals. In the view of the Task Force, this listing could be reduced to two categories – institutions for short stay and institutions for long stay – to avoid the cost and upheaval of transferring people from one facility to another.

When an older person is admitted to an acute treatment and later to a convalescent facility, sometimes he may not admit how ill he is for fear of losing his bed or room in a nursing home, home for the aged or senior citizen apartment. This fear contributes to his insecurity, and it is the view of the Task Force that he should be assured that his "home" is indeed his home and must be available on his discharge from an active treatment institution. Moreover, the loss of previous accommodation results in a backing-up of patients in active treatment hospitals awaiting somewhere else to go. There should be more coordination among the active and chronic hospitals, nursing homes, homes for the aged and other community resources.

With the accumulation of chronic patients in their active beds, some general hospitals may believe that they could save money by converting active beds to chronic beds. Most often, however, they do not provide the variety of programs which must be offered to chronic patients. If this were taken into account, the cost differential would be reduced, and the Task Force recommends:

Recommendation 7. *THAT no acute treatment hospital be considered by the Ministry of Health for conversion into a chronic care facility unless an engineering study has first been conducted which demonstrates that the facility is appropriate and that it can be converted at a reasonable cost.*

Before admittance to a home or other institutional facility, efforts should be made to determine what could be done to help a person remain in the community. Elderly people may need a number of different services and, while these are sometimes available, they often find it difficult to locate and obtain the appropriate service. Discouragement is a serious consequence. In order to overcome the present difficulties in coordination, it is recommended:

Recommendation 8. *THAT coordinators of senior citizens' services be appointed at the local level of health care and social services delivery, that is, the municipal level, to assist elderly persons and professionals working on their behalf, to secure the variety of different health and social services required, and to identify gaps and deficiencies.*

The following were identified by the Task Force as special problems in the delivery of health care to the aged:

1. A lack of appropriate professional attitudes.
2. A lack of professional skill and knowledge in geriatrics.
3. A lack of knowledge of multi-disciplinary team approaches.
4. Mobility requirements (taking the services to the people who have difficulty getting to the services).
5. A lack of coordination of resources and flexibility – inability to transfer patients from one level of service to another.
6. Inappropriate emphasis on the nature of service (acute, intermittent, instead of preventive, supportive and ongoing).
7. Inappropriate funding (OHIP fee-for-service excludes the nurse practitioner, while hospital insurance emphasizes acute care and funding is tied to the length of stay. Funding for nursing homes and homes for the aged encourages institutional care).
8. Lack of evaluation of services and programs.
9. Lack of public information on aging and its effects.
10. Control of costs.

A careful and critical examination indicates that what we have in Ontario is not being used well and we do not have enough services and a consistent pattern throughout the Province. Many elderly people and families do not know how to get services and often get lost between services. Admission and discharge to and from institutions can be poorly admin-

istered. Coordination between hospitals is rare; coordination between hospitals and nursing homes and homes for the aged is rarer; and coordination between hospitals and housing authorities and social agencies is even worse. To achieve a continuum of care, there must be coordination among all these services. A start in this direction would be to integrate or coordinate different types of health institutions. These coordinated facilities (Homes and Hospitals), even though under "separate ownership", could act as a team and place the patient in the facility most appropriate to his needs, keeping in mind the medical care necessary, as well as the cost involved.* The Task Force recommends:

Recommendation 9. *THAT the Ministries of Health and Community and Social Services encourage the functional integration of nursing homes, homes for the aged, chronic care hospitals and general hospitals.*

*Sam Ruth and Stephen Ruden: "Geriatrics and the Health Care System", *Hospital Administration in Canada,* Vol. 19, No. 4, April 1977, pp. 35-40.

Chapter 3:
Areas of Special Investigation

A) Health Services

The Task Force recognized that it could justifiably consult with practitioners in almost every field affecting the health of the elderly. It chose carefully to invite specialists from eight fields to enable representatives of a variety of aspects of health care to express the views of their respective professions. In addition, representatives of several health and social services which directly or indirectly meet health care requirements of older persons in Ontario – home care, housing, institutional care and nursing homes – made presentations in response to formal invitation.

(1) *Rehabilitation*

Although there are other aspects to rehabilitation, including the practice of physical medicine, the Task Force chose to invite representatives of physiotherapy and occupational therapy to present the views of their respective professions.

Physiotherapists feel that there is a growing need for rehabilitation services for the aged, which include physiotherapy, occupational therapy, speech therapy, and audiology services. These are all available to a greater or lesser degree in certain institutions, private agencies and in the general community. Nevertheless, there are significant weaknesses in the present system in that these professionals have had little specific education in the problems of the elderly and the supply of services tends to be limited to the larger hospitals and institutions.

There is consensus in the field of rehabilitation that the goal should be to keep people in their own homes as long as possible. Many individuals occupying beds in the institutional system might remain at home if greater community support services were available. These support services could include help and advice concerning the basic requirements of daily living, such as home maintenance, food purchasing, recreation, advice on how to use the health care system and how to obtain assistance with hearing and sight loss.

In order to achieve these goals, physiotherapists made specific proposals to the Task Force which included: an increase in community programs under both public and voluntary auspices; increased education of all health professionals in the management of elderly persons;

increased support for families including rehabilitation and maintenance programs, arrangements for holiday relief and visits to day hospitals for diagnosis and treatment; programs of counselling to enable retired persons and those nearing retirement to deal with their future and to find new vocations or avocations; and the provision of a variety of residential care facilities to be used flexibly. Physiotherapists consulted by the Task Force also proposed that members of their profession should be engaged in all types of long term care facilities to provide advice to staff on management of specific problems.

Occupational Therapists visualize their role as professional practitioners with two major functions:

1) to treat the physical or emotional condition which causes a person to be hospitalized;

2) to act in the prevention of institutionalization.

The main problems all occupational therapists treat in the elderly are post-stroke conditions and arthritis. Their unique contribution is seen as assessment, which implies a social and emotional assessment as well as a physical assessment. A social assessment would also be helpful in discharge planning. A visit by the occupational therapist to the home of a patient about to be discharged could be of great assistance to the family, with suitable recommendations made as to how to adapt the living situation to cope with the disability.

Occupational Therapists consider they should become seriously involved in home assessments in senior citizens apartment buildings erected under public auspices. The social needs of tenants in apartment buildings are not always met and this may lead to further physical breakdown. Occupational therapists would also wish to be involved in pre-retirement planning. Every effort, in their view, should be made to allow all elderly persons to continue their lifestyles wherever they choose to live, as long as possible.

The senior occupational therapist consulted by the Task Force made specific proposals which included: education of occupational therapists in Ontario should include training in the assessment and management of the problems of old persons; the staff of long term care facilities should receive basic training to maintain functional capacity of the elderly residents, some with specific training and responsibility in using creative and social activities for this purpose (such as adjuvants in homes for the aged) should exist in every facility; and occupational therapists should be more involved in community support programs assisting old people to remain at home.

The Task Force views the main roles of physio-and occupational therapists as assessment and in short term care – the physiotherapist being in the field of physical needs and the occupational therapist in the areas of daily living, social and emotional needs. There is clearly an overlap in the latter view with respect to the roles that social workers in health care settings view as their responsibility, and some overlap with nursing roles.

Long term or maintenance programs should, ideally, be carried out by trained aides. The significance of the "adjuvant" program, which began in 1959 in Homes for the Aged, is that it provides backup for continuing therapy between the visits of physio- and occupational therapists to institutions. The adjuvant is a "mini-therapist" who is employed in the institution, and carries on the therapy between the visits of professional practitioners.

In the view of the Task Force the whole field of rehabilitation requires substantial exploration, study and research. Rehabilitation services are the obverse of the coin of prevention. They are potentially significant in preventing admission to a variety of institutions. This is particularly important at a time when the Government of Ontario has cut back sharply on the creation of additional capital facilities in the form of chronic care hospitals, nursing homes and homes for the aged.

(2) *Dental Care*

The Task Force was advised that 60 percent of persons in Ontario, aged 65 and over, need some form of dental treatment. Such treatment may range from examination and cleaning of teeth to major restorations and dentures.

Elderly people make up about 5 percent of an average dentist's practice. Dental education for the elderly is not adequate since there is little information available to them in published form or otherwise. If such education were improved there could be an increased demand for services.

Geriatric dentistry is not seen by specialists as a didactic program of education for all dental professionals, but, rather, as an internship. Nevertheless, consultants agreed that insufficient time is spent in the education of dentists on the natural changes in the mouth due to aging, and on the dental problems of the elderly in our society.

Two methods of improving dental services to the aged would be a "denticare program" and/or travelling dental clinics. The former would be very expensive in the province of Ontario*. It is considered, however, that there would be enough professional manpower to establish such a program in Ontario through private dental offices.

To date, travelling dental clinics have been made available only to children living in remote parts of the province of Ontario or where dental services are not available within reasonable distance. Mobile units are driven to such communities and, in cooperation with Boards of Education, are located on school grounds. In the experience of officials of the Ministry of Health elderly people have not demanded a travelling clinic but are increasingly requesting dental care services.

The Task Force was of the view that it may be difficult to justify a dental plan for the aged in Ontario under public auspices especially where there is no universal insurance plan for children in this Province. Denticare would not dramatically improve health or save lives. However, it would not be difficult to develop a dental plan for the elderly in Ontario under public auspices, especially as many dental services could be provided by dental auxiliaries working in association with dentists. A case could be made that adequate dental care would enable older people to eat properly, to ingest better nutrition and thus to enjoy greater health and energy.

Recommendations derived from this exploration of dental problems of and dental care for the elderly are:

Recommendation 10. *THAT the Ministry of Health give consideration to the payment of all or part of the cost of certain major dental procedures and prostheses for the elderly, eligibility to be determined on the basis of need.*

Recommendation 11. *THAT the Ministry assist hospitals, other institutions and local official health agencies to develop dental clinics which would provide care for the elderly.*

(3) *Hearing Problems*

Persons who suffer loss of hearing experience significant and substantial problems. Their condition makes for social isolation and a

*On the basis of the experience in Alberta the cost in Ontario in 1976 would have exceeded $100 million.

very lonely life. Causes of damage may be many – antibiotics, gunshots, snowmobiles, loud music, traffic, industrial noise, the increasing noise of the environment in general – but they all result in decreased sensitivity to sound.

As life progresses and people continue to be exposed to these noises, loss of hearing increases. A great deal of hearing can be lost before it becomes bothersome but, by the time a person reaches his mid-sixties it is becoming troublesome. Specialists anticipate that the elderly, within a decade or two, will have significantly worse hearing than older persons have now due to ever-increasing environmental noise. This is supported by the increasing number of claims received by the Workmen's Compensation Board.

The Task Force learned that in the early 1950's, the Workmen's Compensation Board of Ontario began to compensate persons for industrial hearing loss. In 1954 there were approximately 10 claims; in 1974 there were about 1,000; in 1975 and 1976 there were 1,500 and 2,400 respectively. These claims came primarily from members of large industrial unions and from their employers.

Recognition of the increasing incidence of employment-related hearing loss and the payment of compensation are insufficient. It is reasonable to contend that the Ministry of Labour, through its Occupational Health and Safety Division should develop both an educational and a functional program, in conjunction with the Workmen's Compensation Board, to reduce noise levels in industrial employment and thus to assist in the prevention of hearing loss.

The experience of specialists indicates that the elderly are reluctant to spend the money required for hearing aids, the average cost of which is about $250. Hearing aids are usually simply marketed, whereas there is a need for time to be spent with the purchaser to teach him how to use it properly. This could be carried out by people who already have hearing aids.

A consultant to the Task Force believes that society would derive more benefit from the provision of hearing aids, when accompanied by a process of follow-up and rehabilitation, than from such programs as the provision of costly diagnostic equipment. An adequate rehabilitation program is not yet funded. If this were made available, together with society's determination to quiet environmental noise, fewer people would have hearing problems.

There is also concern about the supply and distribution of trained professional personnel such as audiologists, who are needed to conduct essential audiometric tests, and hearing aid technicians. At the present time there are some 50-60 professional audiologists in Ontario, with a training school only at the University of Western Ontario. If the provision of hearing aids were to be funded there would be a considerable increase in demand for technicians, for whom a short training program is only available at the University of Toronto. Moreover, distribution of workers in the field of hearing is unsatisfactory because they are clustered in areas of the province where facilities are available.

The Task Force agreed that fundamental recommendations in the field of hearing problems must include the following:

Recommendation 12. *THAT the Ministry of Health give consideration to the payment of all or part of the cost of hearing aids for the elderly, eligibility to be determined on the basis of need.*

Recommendation 13. *THAT the Ministry of Health request the Ontario Society for the Deaf, the Canadian Hearing Society and hospitals which dispense hearing aids, to institute a program of follow-up service for those who have purchased (or received) such aids*.*

Recommendation 14. *THAT the Minister of Health request the Minister of Colleges and Universities to encourage an increase in the number of audiologists and support staff trained to deal with the increasing frequency of deafness in the population.*

(4) *Eye Care*

The importance to an elderly person of maintaining visual function consistent with his age, is axiomatic. Loss of sight associated with loss of independence, is a major precipitating cause of institutionalization. Unfortunately, among Ontario residents now 65 years of age and over, there is evidence of considerable neglect of adequate care of their eyes in the years of their youth and middle age.

This situation is aggravated by the problem of distinguishing between more than one professional and para-professional with potential

*The Select Committee on Aging of the Legislature of Ontario recommended in 1967 that all hearing aid companies, salesmen and promotional activities be licensed and controlled. Adoption of this recommendation could provide Government with the power to insist upon follow up services.

responsibility for eye care. It is difficult for the general population and perhaps more difficult for older persons to understand the expertise and roles of an ophthalmologist (or oculist) who is a medical specialist, a general medical practitioner or family doctor, an optometrist who is trained to carry out refractions, prescribe eye glasses and recognize signs of eye disease which necessitate referral to an ophthalmologist and an optician, who is a businessman engaged in the filling of prescriptions and the marketing of glasses. Since both ophthalmologists and optometrists conduct eye examinations and tests of refraction, potential confusion is understandable.

Consultants to the Task Force included an ophthalmologist and an optometrist, both with seniority and distinction. It was learned that each year general practitioners provide about two million eye care services in the Province, dealing with such conditions as conjunctivitis and referring more serious problems to an ophthalmologist. Ophthalmologists, numbering about 300 in Ontario, provide about one million services including treatment and essential surgery; while optometrists, who number about 600, provide about half a million services for refraction and glasses. The role of general practitioners is clearly very important and we undertand that the College of Family Physicians has indicated that they would like more preparation on eye care.

Disease of the eyes is possible at all ages but beginning at about age 50 the incidence begins to rise significantly. By age 70, more than 50 percent of the elderly have problems of considerable importance. Diseases which can be controlled or cured become common: cataracts, glaucoma, lid problems, retinal detachment. Diseases which cannot be cured increase in incidence and morbidity, especially macular disease, diabetic retinopathy, and pigmentary degenerations. A consultant felt that the expertise needed for old people is at the limit of present scientific ability; the care needed is detailed, either to help or to cure; and the whole must be handled with quiet confidence and with compassion.

The annual output of ophthalmologists for the five medical schools in Ontario is about 15. The ideal ratio of such specialists to population is considered to be 1:30,000; in 1976 the actual ratio was approximately 1:27,888. In the past about half of the number of ophthalmologists in Ontario was supplied through immigration, but with the decrease of physicians coming from other countries and the significant exodus to the United States, the numbers available in the future may become insufficient. Distribution is a problem in

view of the reluctance to practice in smaller communities, particularly in Northern Ontario. Thus in Toronto the waiting period for cataract removal is not long -- three or four weeks, but in the smaller centres this may be months or more since ophthalmologists are less readily available.

There is just one educational program in optometry in Ontario, specifically the School of Optometry at the University of Waterloo. Since its inception the School has addressed itself to the problems of aging and to this end has evolved several clinical training experiences for its students, who number 60 per year in a five-year course. In particular, a survey of the prevalence of vision defects and ocular anomalies was conducted in 43 Ontario residential facilities – homes for the aged, nursing homes, and Ontario Housing senior citizens' apartments. This study showed a considerable need to correct refractive errors, a need for low vision assessment, disease detection and subsequent referral for medical and/or surgical treatment.

The degree to which the institutionalized population is underserviced was considerably greater than expected. Among the people examined two-thirds were found to need care; most had not been seen for two to five years. Half of those examined were referred to ophthalmologists as a consequence of the discovery of cataracts, glaucoma and degeneration of the optic nerve among the residents. Although OHIP pays for the medical or optometrical service it was found that the cost of glasses stops many people from seeking care. The Task Force recognizes that a one-time survey has value only in special situations – for example, a complete lack of local service – unless there is continuity of contact by a general practitioner and the maintenance of adequate contact records.

The proposals of the optometrist who spoke to the Task Force included: the placement of optometrists in the public health system (an optometrist in a public health unit would be fully occupied with services to residents of nursing homes and to pre-school and school children); encouragement for more optometrists to settle in communities in Northern and Eastern Ontario, where unmet need is substantial; and that an evaluation of lighting facilities be carried out in every nursing home and home for the aged (since the Waterloo Survey demonstrated that with increasing age residents require far greater illumination for visual acuity).

A program for eye care put forward by the ophthalmological consultant to the Task Force would be to set up for each group of

elderly persons in Ontario – those residing in institutions, those living with their families and those living alone – a method of continuing contact and a system of records; allowing the general practitioner to be the leader within the continuing contact; establishing routes of referral for both services and appliances (glasses); and ensuring necessary transportation and purchase of appliances and drugs.

In consideration of its consultations and analysis, the Task Force recommends:

Recommendation 15. *THAT the Ontario Medical Association and the Ministry of Health encourage family physicians, general practitioners and personnel of local health agencies, to conduct regular visual appraisal of their elderly patients and referral for specialist eye examinations where required.*

Recommendation 16. *THAT the Ministry of Health and Ministry of Community and Social Services consider arrangements for regular visual appraisal and referral for specialist eye examination where required, for all residents in nursing homes and homes for the aged in Ontario.*

Recommendation 17. *THAT the Ministry of Health give consideration to the payment of all or part of the cost of eyeglasses for the elderly, eligibility to be determined on the basis of need.*

(5) *Mental Health*

Geriatric psychiatry or psycho-geriatrics is a relatively new branch of psychiatry. A consultant to the Task Force, after more than two decades of experience, has divided his patients into four groups:

1. People who are aged 65 and over, who are well, healthy, able and willing to work, but frequently not permitted to continue working in their chosen employment by virtue of their age. Members of this group are the first generation to experience enforced retirement leisure time. They may become isolated and develop situational depression.

2. People who suffer mainly from chronic degenerative disease, in some cases to the point of incapacitation. Most also suffer from situational depression. This group is generally treated through the use of psychotherapy, should not be placed in institutions unless an illness necessitates it, but should be rehabilitated,

patiently and consistently, by physiotherapists, occupational therapists and other professionals.

3. People with functional psychoses who require psychiatric treatment. In the case of depression good results are normally obtained. Not all of these patients need to be institutionalized.

4. People who are demented. They are usually found to be suffering from atherosclerotic brain disease, senile or Alzheimer's dementia, or a combination of these. Some patients can be maintained for a limited period of time by psycho-pharmacology. By patient teamwork they can be helped to spend the rest of their lives in a happier state.

There are no reliable statistics to determine what percentage of the elderly population – not the psychiatric caseload – fits into the four categories briefly described. It is possible, according to a consultant, that 10 percent of this population suffer from a dementing process.

In institutional settings psychiatrists are asked to see residents with a variety of psychiatric problems which usually come first to the attention of the nurse, social worker or administrator. To help with the behaviour of the older person and to influence the way the individual feels toward himself and his environment, the psychiatrist may use psycho-therapy, psycho-pharmacology, group therapy, and sometimes electro-convulsive therapy. In a therapeutic team approach each professional person has a contribution to make in dealing, in a flexible manner, with the older people and in fostering the helping process.

The Task Force learned that a very good example of the kind of facility required for geriatric psychiatry would be the 14-bed clinic which was established at the Royal Ottawa Hospital some years ago for short term treatment. The staff of the clinic included a general practitioner, a psychiatrist, a social worker, an occupational therapist, and nurses – all of whom chose to work in this setting. Services offered included those of a day hospital, out-patient assessment and treatment, follow-up, occupational therapy and group therapy. The average length of in-patient stay was 26 days. Liaison was maintained with all geriatric services in the community.

In the view of our consultants there would not appear to be a great need for long-term institutional care, especially of the "mental hospital" type. Nursing homes and homes for the aged could be more

therapeutic rather than primarily residential. There must be a method developed whereby residents admitted for short-term care to hospital would be guaranteed readmittance to their place of residence. At the present time a patient absent from a nursing home for more than 72 hours may be 'struck off the list' unless his family wishes to pay for the bed in his absence.

A common need in institutions, often unmet, is the development of programs and environments for the protection and support of persons with impairment of mental health. The type of person who requires this service is the most difficult to place – he is a person who could live in the community, perhaps with his children, but tends to wander away. Nursing homes are not equipped to take care of such persons. The individual is not ill enough for a chronic hospital and should not be placed in a mental hospital. A few homes for the aged, which would seem the ideal place for this type of ambulant person, have such facilities but there are not enough.

In summary, the needs in psychiatry for the aged are efficient case-finding, adequate institutionalization to provide safe shelter, patient teamwork to restore the individual's self-esteem and to help him make the rest of his life happier. Improvement in psychiatric care for the elderly may be met in the following ways:

Better coordination and placement

Establishment of psycho-geriatric units in hospitals

Increased numbers of "special care" beds

Encouragement for nursing homes to accept patients who require nursing services beyond what can be provided at home and to refuse persons needing minimal care where such care is available from community agencies

Allowance for return to their residential care home when the person has been absent because of the need for temporary care in another location

Encouragement for "good" people to work in geriatrics and gerontology – now considered an unattractive field – perhaps through financial incentives

Increased numbers of occupational therapists and social workers to work with older patients

Increased numbers of professionals (public health nurses and social workers) to deal with case finding in the community

Expanded instruction of family physicians in geriatric care so that they will be able to recognize problems in their patients

Inclusion of geriatrics in the general medical curriculum

Training to increase the capacity of persons working in the management of geriatric patients

It is reported that 20% of the population age 65 and over manifest an impairment in mental health demonstrated by emotional disturbance or forgetfulness which can be ameliorated by appropriate treatment. Suicide is more common in middle age and late life than in younger years. A review of OHIP information for 1976-77 shows that only 4.75% of psychiatric services billed to OHIP were for people 65 years of age and over. This low proportion may be explained in part by the fact that the services of psychiatrists to elderly people are largely provided by doctors employed in the mental health services in Ontario.

The recommendations of the Task Force concerning mental health are:

Recommendation 18. *THAT the care in any long term care facility where there are mentally impaired elderly residents be built around the concept of reality orientation (a treatment modality emphasizing mental stimulation through social interaction concerning everyday life).*

Recommendation 19. *THAT there be developed in long term care facilities, appropriately licensed and approved programs and environments for the protection and support of persons with impairment of mental health.*

Recommendation 20. *THAT where freedom of movement is restricted (closed units) there be very clear procedures for periodic re-assessment and a mechanism of right to appeal by the patient or his personal representative.*

Recommendation 21. *THAT the Ontario Medical Association and the Ministry of Health identify ways in which health professionals can provide increased mental health services to the elderly, specific to their needs and problems, both in community settings and in residential institutions.*

(6) *Drugs and Medications*

All residents of Ontario who are 65 years of age and over receive prescription drugs without direct cost under The Drug Benefit Pro-

gram instituted by the Provincial Government in September, 1974. This Program also covers persons of any age who are residents in homes for special care, nursing homes and homes for the aged, who are receiving home care, who are medically indigent diabetics, and persons in receipt of general welfare assistance or family benefits.

In 1976 the number of residents eligible for benefit under the Program was 1.2 million; approximately 60 percent were elderly people. One million drug benefit prescriptions were dispensed each month with an average utilization of 11 prescriptions per eligible person per annum. The average cost was $56. per capita; the total cost was approximately $67 million in 1976. Since older persons utilize the services of physicians (general practitioners and internists) more frequently than the population as a whole, their share of the total cost of the Drug Benefit Program might have reached $45 million.

For the elderly the Program is not based upon a test of means but is universal. Drugs paid for by the plan are listed in a 1600-item Formulary which is amended through expansion or deletion from time to time. If a physician wishes his patient to receive a drug that is not listed he may make a special application for the particular drug to be paid for under the Plan. It must be true, under all circumstances, that the costs of drugs and medications is not a source of economic deprivation for older people.

It is clearly understood by the Task Force that this system may lend itself to a variety of abuses – by physicians, by elderly patients, and by pharmacists. Some elderly persons consulted by the Task Force expressed the view that some physicians, tired of multiple office visits by elderly clients, write out a prescription in the belief that this pleases and satisfies such patients. It is then possible for older persons to avoid questions from professionals who have some knowledge of their health problems and drug regimes – and to accumulate drugs which may or may not be taken, may be used inappropriately with other medications, or may be given to friends. The extent of such abuses is unknown. It should be emphasized that a group of elderly consulted by the Task Force insisted that most persons were careful and discreet in their use of prescribed drugs and that abuses were rare.

At the present time pharmacists receive a dispensing fee of $2.85 per prescription. On this basis they were paid $31.35 of the $56. per capita for the average of 11 prescriptions per year per eligible resident covered by the Drug Benefit Program. It would appear that

pharmacists received about $37.5 of the total expenditure of $67 million in 1976. The Task Force believes that this is an excessive proportion and that terms should be re-negotiated.

On the other hand the pharmacist may play an important role in counselling older people in the use of drugs and medications. Drugs are dispensed in monthly supplies under the Program and in this way a pharmacist can monitor their usage, can instruct clients on how to take the drugs and may question them to determine whether or not they are receiving other prescriptions from other physicians. A study at Sunnybrook Hospital has indicated that elderly people take, on the average, 2.5 different drugs at any one time. The Task Force learned that, increasingly, pharmacies and institutions are maintaining "profiles" on their clients, based on computerized systems or files.

In the conviction that there are serious and costly weaknesses in the Drug Benefit Program, the Task Force recommends:

Recommendation 22. *THAT the Ministry of Health, the Ontario Medical Association and the College of Pharmacy jointly develop a mechanism for control and monitoring of the dispensing of drugs and medications to elderly persons at home or in institutions, to ensure safe use at reasonable cost.*

Recommendation 23. *THAT the Ministry of Health request the Ministry of Community and Social Services to give consideration to various mechanisms of dispensing drugs to institutions, including the capitation system for which a pilot program has been established in the Niagara Region.*

Recommendation 24. *THAT the Ministry of Health institute a review to determine avoidable excessive costs of the Drug Benefits Program as it exists at present.*

(7) *Care of the Feet*

Althout the Task Force did not have a formal consultation with representatives in podiatry or chiropody, it did discuss this matter with groups of elderly persons. In addition, it has available the 1973 Report of the Ontario Council of Health on Chiropodists in Ontario which favours strongly the development of a group of technicians, partly through the importation of chiropodists from other countries, presumably the United Kingdom. This was preferred for two reasons:

a judgement concerning the needs of persons for foot care, that is, a judgement that a fully trained professional podiatrist is less necessary than a chiropodist who is, essentially, a skilled pedicurist. The second reason was presumably the matter of cost.

It is clear that elderly persons have very great difficulty in caring for their feet, although simple pedicures may be obtained from a physician or nurse in the course of a general visit. Our elderly consultants strongly wished that arrangements could be made for a chiropodist or a podiatrist to hold foot care clinics at regular intervals within the buildings where senior citizens live; such a clinic at local hospitals would also be helpful.

There is no school in Canada for the training of either podiatrists or chiropodists. The majority of chiropodists are trained in Britain and their activities relate to "caring for" feet in the provision of pedicures and removal of corns and callouses. They are not permitted to practise in Ontario at the present time and may not be licensed*.

Podiatrists are trained in the United States graduating after a long program (up to 7 years) as doctors of podiatric medicine (D.P.M.). Their practise in Canada may be considered as overlapping with physicians. In the U.S. they may admit patients to hospital, perform certain surgical procedures and prescribe drugs; none of these three functions are permitted in the province of Ontario. Podiatrists may practise in Ontario under the Chiropody Act (Ontario).

It is the view of the Task Force that the whole question of foot care has been underestimated. Mobility is often the factor which makes it possible for the older person to remain in his own home, to live in his own neighbourhood and to live as normal a life as possible. The inability to walk comfortably, to obtain proper footwear, inhibits mobility and may be one precipitating force toward early institutionalization.

The Task Force concluded that the type of foot care specialist required by senior citizens, for the majority of their requirements, is the chiropodist. There is a substantial need for increased numbers of chiropodists, who should be permitted to offer their services independently, within a defined scope of practice. There is also a need for expansion of such services to nursing homes and homes for the aged. The Task Force supports the position of the Ministry of Health in this matter and believes educational programs should be

*The Task Force understands that amendments to the Health Disciplines Act are now in progress.

established in Ontario at the level of the colleges of applied arts and technology. It recommends therefore:

Recommendation 25. *THAT the previous recommendations of the Ontario Council of Health, in Council's Report on Chiropodists in Ontario, 1973, be implemented; and,*

THAT the Minister of Health request the Minister of Colleges and Universities to take steps to increase the number of chiropodists available in the Province by the establishment of educational programs in the Colleges of Applied Arts and Technology.

Recommendation 26. *THAT the Ministry of Health permit chiropodists to offer their services, after licensing, within a defined scope of practice.*

Recommendation 27. *THAT greater emphasis be placed on the importance of foot care for the elderly and, to this end, the appropriate Ministries encourage nursing homes and other institutions to recruit qualified chiropodists to serve residents and members of the community on a part-time basis.*

(8) *Nursing Care*

Nurses have a special place in that part of health care usually described as medical care – the diagnosis and treatment of disease processes – because of their continuous contact with people in illness and periodic or continuous contact in a variety of settings with people who are well. Because of their educational preparation in health sciences and because of their special training in communicating and relating to people, nurses are able to undertake case-finding, monitor illness states, and help individuals implement the medical treatment component of their health care*.

In respect to the delivery of health care to the elderly the major and specialized contribution of nursing rests in a series of interventions different from, but not excluding, medical care. Older persons are confronted with a number of actual and potential crisis situations and nurses are strategically placed in the health care system at points where help in adjusting to these crises can be activated and maintained.

*J. Mantle. "Nursing's Contribution to the Quality of Care". An address to the Gerontological Nursing Association, Toronto, June 3, 1977.

Nursing is a major component in the treatment services and medical and social management offered within acute general hospitals, convalescent and nursing homes, chronic care hospitals, and homes for the aged. It is in the community, however, in which the role of nurses beyond participation in medical care, is fully exercised. As employees of local or regional public health departments nurses are no longer simply described as 'public health nurses' but more often are termed 'community nurses'. Community nurses and visiting nurses, usually employed by such voluntary organizations as the Victorian Order of Nurses and the St. Elizabeth Visiting Nurses Association, are probably in contact with more elderly people on a continuous basis than the members of any other professional group.

The Task Force consulted with two nursing specialists, one a clinical nurse specialist in an extended care program and the second with intensive experience in visiting nursing and the provision of services in a Home Care Program. The elderly sick in the community constitute a high proportion of the case load of home nursing programs. In one of the three Pilot Chronic Home Care Programs begun in Ontario in 1975, 84 percent of the patients in 1977 were over 65 years and 40 percent were over 80 years of age. During a six-month period ending September 1977, the greatest need of patients was for the professional service of nursing with 96 percent requiring nursing care. By contrast just 9 percent required physiotherapy and 7 percent, occupational therapy. The services of homemakers were needed by 45 percent of the patients.

Early referral to community nursing services can retard deterioration and lessen family stress but this requires a knowledgeable professional and client population. Knowledge of the community and its resources within either group cannot be taken for granted. While the majority of the elderly prefer to be at home, they are disadvantaged by a lack of knowledge about available community services and are confronted by a health care system which is fragmented and lacking in coordination. As one consultant expressed the problem, "The Home Care Program can, however, only coordinate services that are already in the community".

The sick elderly have need of services from both the health and social systems and there are some services that are still lacking in the community. The services of chiropody/podiatry, dental care and help with living with hearing deficits are frequently lacking. To be practical long term care requires homemaker services, chore services, meals on wheels and a variety of services which fall within the social sphere.

Deficits in all these health and related social areas have direct impact on the social behaviour of older persons.

The consultants suggested that volunteer services could be developed to provide visitor services to the socially isolated elderly and to offer relief for those families involved in maintaining a chronically ill person at home. If they are to be effective volunteer programs should be coordinated by a salaried manager and instituted only after an assessment by a health care professional.

The clinical nurse specialist consulted by the Task Force reinforced the necessity of using a team approach in the delivery of health care to older persons in any setting because of the complexity and multiplicity of problems for which no one discipline has all the answers.

The nurse in the institutional setting was seen as the leader of the health care team who, in conjunction with the physician, presents the problems for health care management, provides nursing care and coordinates the programs planned. The community health nurse working with the sick elderly was described as helping the patient and/or his family adapt to the fact of chronicity, participating in the medical care, helping with adjustments in the activities of daily living, creating a safe physical environment, and in assisting families with the caretaker role. The public health nurse was seen to have a particular contribution to make in health teaching and in monitoring older persons in their home environment.

The consultants were supportive of the role of the nurse practitioner who has additional preparation, especially in the area of physical assessment. These nurses were seen to be very effective in extended care institutions and in nursing the elderly chronically ill in the community where illness incidence is high and medical resources are less available or very costly. At least one long term care institution in Ontario employs a clinical nurse specialist trained to the Masters Degree level, who functions as a consultant and resource to all nursing staff in the agency. A nurse prepared at this level represents the specialist in geriatric nursing.

The Task Force was made aware that the majority of nurses have no educational preparation in gerontology or geriatrics. A lack of exposure to the satisfaction to be gained from working with older persons as well as less attractive working conditions have operated against nurses being attracted to this area of practice. At the time of writing it is not known how many prepared nurses are currently employed in this field. Adequate planning will require this determination. A

few courses in long term care nursing are offered in community colleges at the post diploma level. In order to specialize at the post-baccalaurate level, the nurse is required to leave the province for in-depth study.

Summary

All of the consultations undertaken by the Task Force, whether concerned with the direct practice of health care or a specific professional or para-professional service, were focussed upon three sets of questions:

1. What is the nature and extent of problems among the elderly in Ontario which require the provision of a specific health service and related social service? Are there difficulties in delivering these services under the present system of organization? How much unmet need is there estimated to be and how is such need measured?

2. What are the types, numbers and roles of the various categories of manpower available to deal with these problems and/or provide required services? In what educational programs and in what numbers are they being trained? Are human resources in sufficient supply at the present time and will they be sufficient to meet the needs of the increased number of elderly in the future?

3. What gaps or weaknesses now exist in service provision? What proposals for new programs or recommendations for change in existing policies and programs should be made?

It is clear from the presentation of a relatively brief analysis of discussions with consultants that in many fields there is a substantial degree of unmet need as, for example, in hearing, mental health, eye care and physiotherapy. The amount of such need is not known with exactitude, and perhaps cannot be measured fully since elderly people live alone, as well as with their families, and may be detached from the health care and social service systems. Nor does the fact that some 8 percent of the elderly in Ontario live in residential institutions guarantee that their health care needs will be fully met.

There are now insufficient supplies of professional or para-professional personnel to provide certain required services as, for example, audiologists, hearing aid technicians, optometrists, chiropodists, physio- and occupational therapists, social workers and homemakers. Of more importance, there is great concern about the future. It is eminently clear that by the end of the century there could be deficiencies among

many groups serving or working with elderly people, including otologists and ophthalmologists, psychiatrists and physiatrists. Moreover, medical education for general practitioners and most specialists is said to be quite inadequate in its coverage of the biology of aging, the diseases of the elderly and their treatment.

There is major concern, as well, respecting the probable gross shortage of residential facilities for the "old-old" within two decades. The fact that the institutionalized population will be older, and thus perhaps more seriously ill, is a further cause for anxiety. The percentage of Ontario elderly in institutions may not increase even if a number of new programs are developed and expanded to enable people to continue living in the community; the total will not decrease because of the great growth in numbers of elderly people. This would inevitably mean about twice the present number of residents. At this time such space does not exist, nor is it under construction.

The Task Force recommends, therefore:

Recommendation 28. *THAT the Health Manpower Planning Section of the Ontario Ministry of Health continue and strengthen its effort, with the advice and assistance of the Human Resources Committee, Ontario Council of Health, to establish the balance or imbalance between supply and demand and to encourage proper distribution among the health care professions required to serve elderly persons over the next three decades; and to develop health manpower plans to meet estimated staffing requirements.*

Recommendation 29. *THAT the Health Manpower Planning Section of the Ontario Ministry of Health establish a formal relationship with the Senior Citizens Branch and Office on Aging, Ontario Ministry of Community and Social Services, to explore the supply of and demand for members of social service professions and related occupations required to serve elderly persons now and in the future, and to develop the framework for and the process of manpower planning within the Ministry.*

Recommendation 30. *THAT the Ministry of Health undertake a study of the current supply and probable requirements for chronic hospital and nursing home beds, by five-year periods during the balance of the century, and develop plans to provide required institutional facilities through new private construction, expansion of existing homes and appropriate conversion of existing buildings in the community to such uses; and*

Recommendation 31. *THAT the Ministry of Health request the Ministry of Community and Social Services, perhaps jointly with the study of chronic hospitals and nursing homes, to undertake a study of the current supply and probable requirements for beds in homes for the aged, by five-year periods during the balance of the century, and develop plans to provide such institutional facilities as are required in appropriate locations.*

B) Residential Services: Housing as a General Problem

Decent, adequate, and safe shelter at an affordable price is a fundamental requirement of every individual and family in our society. In the case of elderly people this is a particularly complex matter, replete with a number of dilemmas for consideration by elected and appointed officials and by the elderly themselves.

Most older people in Ontario live in their own homes, and a substantial proportion of such housing accommodation is owned by these occupants. This would seem to solve the basic problem until one looks beneath the surface at the problems and issues which face an older person or an elderly couple as they continue to age in whatever housing accommodation they inhabit. As far as home ownership is concerned there is at least a dual problem: the matter of maintenance and general repair becomes more difficult as people age and are less able to undertake their own work; and secondly, there is the question of the diminishing capacity of older people to pay increasing municipal taxes, increasing charges for utilities and heating, and higher costs of maintenance since their incomes are generally stable, or rise at a far lesser rate than the average individual or family income.

Older couples who rent accommodation in Ontario villages, towns, and cities, are perhaps even more in difficulty as time passes. Rental rates in certain rural communities or villages and small urban centres are clearly fewer in dollars than in larger towns and urban centres, but they are not necessarily a smaller proportion of the total income of older persons. In fact in many small communities in Ontario the matter of renting rooms and flats – often over commercial premises on main streets – is an important activity for owners of property.

In the larger towns and cities rents are frequently quite high in dollar terms and as a proportion of total available income. Moreover, the quality of rental premises available to older people in larger communities is often quite poor. The single person, living on a modest income even under relatively generous provincial income maintenance programs, may spend 40-60 percent, or more, of his total income on rent, perhaps

for one room in a large house in the central area of the city, and often without adequate light, ventilation, or sanitary facilities.

It is for all these reasons that Federal-Provincial Programs of socially assisted housing for the elderly have developed since the 1950's and are now an important proportion of total housing activities under public auspices in this province. In 1978 there will be nearly thirty thousand dwelling units developed for senior citizens under the aegis of the Ontario Housing Corporation during the past decade, administered by more than fifty Local Housing Authorities. These are already evident in more than two hundred municipalities in the province. In addition, the Metro Toronto Housing Company Ltd., with responsibility for senior citizens' accommodation in the greater Toronto area, will have a stock of some ten thousand dwelling units in 1978.

The dilemmas arise both in the economic and social aspects of the overall situation. It is not at all clear how many dwelling units are required by elderly persons because this judgement is in part based upon surveys of need and demand in local areas. Such surveys are sometimes proven quite inaccurate when the actual physical accommodation is available for rental and the demand is not forthcoming. There is said to be a surplus of senior citizens' housing available for rental (under rent-geared-to-income scales) in such cities as Ottawa and London, but sometimes this is a function of location, transportation and shopping facilities and the like. Elderly persons have the right to choose whether they shall leave current accommodation and move to senior citizens' housing, and sometimes deliberately choose to remain in familiar surroundings despite higher shelter costs. Nevertheless, the housing created by public authorities is costly to build and the losses (subsidies) are substantial.

The economic dilemma is further compounded by the fact that whereas monthly and annual incomes of most elderly persons are relatively low, the income data do not always reflect the total asset position of the individual or elderly couple. Those who own their own accommodation may occupy far more space than they need but are in possession of a valuable asset in housing market terms. When they choose or are required, for health reasons, to sell the house they have owned for some time, they usually come into possession of a substantial amount of money. A simple capitalization of these assets at a modest rate of interest may elevate their income substantially above the levels of those most in need of senior citizens' accommodation. It is not unusual therefore, for elderly individuals or couples to assign or give these assets to their children so that their income position remains quite low and their eligibility for senior citizens' housing remains high. In many small com-

munities however, these facts are known to their friends and acquaintances and unpleasant situations arise when they are accommodated.

The Ministry of Housing thus faces a number of dilemmas based upon inadequate forecasts of need and demand and the difficulty of knowing what the total income -- assets position of some applicants will be at the time of available accommodation. In theory, the demand for housing accommodation for elderly people at a price within their capacity to pay is unlimited; in practice, there are questions about over-building in some communities. Moreover, rising costs of construction have meant that the economic rental of new senior citizens' accommodation in the late 1970's is between $250 and $300 per month, depending on location. Deduction of the rental actually paid by the older person still leaves a subsidy of more than $200 per month per dwelling unit to be paid by taxpayers at all levels of government. The total and rapidly rising subsidy account in the Ontario Ministry of Housing and throughout the nation has become a concern both to the federal and provincial governments, particularly as they consider the substantial increase in the number of elderly people over the next two decades.

Rent supplements and shelter allowances are potential alternatives to the further construction of senior citizen housing in communities where the supply appears reasonably adequate. Both techniques are forms of income supplementation designed to enable elderly people to remain in their current accommodation as the increase in shelter costs outstrips the capacity to pay. They will not reduce subsidies in the short run, but they can reduce the requirement for public capital investment and ultimately retard the escalation of subsidies in the long term.

The impact of this consideration of housing accommodation for reasonably well and ambulatory older persons, upon the health care services, should not be ignored. Inability to obtain decent and adequate shelter is a constant source of worry for some older persons; the drain of a very large proportion of the income of many elderly persons for housing accommodation clearly means less money available for adequate nutrition, clothing, recreation, dental care, and certain other health requirements. The neglect of these aspects of a minimum adequate standard of living can mean a more rapid deterioration of health than would otherwise be the case.

Perhaps the most significant complication in the whole matter of residential accommodation arises from the differential needs of older persons at various stages in their aging process, as well as the requirements for both short-term and long-term residence in a health care facility.

Many older persons may be quite able to function in their own homes well into their 80's or later. They may, however, experience illness which requires ultimately some period of residence in a convalescent home or perhaps in a nursing home. It is the question of availability of these facilities which further worries a great many elderly people as they face the possibility of having to leave their own housing accommodation for either short or long term residence. Most persons eventually must give up their own accommodation (rented or owned) and the question of their future residence arises very sharply for themselves, members of their family and the administrators of social and health services.

Within the province of Ontario a substantial variety of alternatives exist on paper but some are in very short supply and others are at an early experimental stage. One of the gerontological principles accepted by the Task Force stresses the desirability of the older person living in his own home as long as possible. When the individual (or couple) is reasonably well, ambulatory and able to provide most or all of their own meals a senior citizens' apartment is the obvious and acceptable alternative. The combination of such apartment facilities with a residence of single rooms with all facilities except the kitchen, is the second best alternative for some persons, particularly when a combined program – apartment/residence complex – is available. Such a facility enables a person to move temporarily from his apartment to a room in the residence or to a bed in a small infirmary under the supervision of a nurse and a medical practitioner.

Two or three voluntary organizations (often under church sponsorship) have created facilities of this kind in Ontario and there is one notable public example known as the Oakville Senior Citizens' Residence. This latter complex, now in its fourth year of operation, permits the residents in one structure to obtain all their meals in a large dining hall, while the residents of the apartment building which is interconnected, may take some of their meals in the dining hall at their own expense. The apartment dwellers pay a rent geared to their income as well as the cost of any meals they purchase in the dining facility; the residents of the non-apartment structure, examined by the physician appointed to this responsibility for the complex, have a substantial proportion of their rent and meals paid for under the Extended Care Provision supervised by the Ministry of Community and Social Services. One or two comparable structures are under consideration within the province but it would appear that many more are required.

Combined programs such as that at Oakville represent cooperation between the Ministries of Housing, Community and Social Services, and Health. They demonstrate that such cooperation is not only psssible but greatly to be desired in meeting the residential requirements of elderly persons.

For some older people, however, even the degree of personal responsibility required in an apartment/residence complex cannot be met and their requirement is for a nursing home, literally a facility where more than a specific amount of full-time nursing care is required each day. Nursing homes are currently licensed by the Ministry of Health, but are under the auspices of independent proprietors who are in business to realize a reasonable return on their investment.

The Task Force was advised that nursing homes are not only no longer under construction with Provincial support and approval (which must be received if a licence is to be granted) but are facing very significant demands for accommodation. Nursing homes in Ontario maintain waiting lists but these are apparently extensive and potentially duplicative. A uniform list maintained by the Assessment and Placement Services of Hamilton and regularly updated shows a relatively constant number waiting (between 200 and 250 persons). In many areas applicants are on the list because they or their families can find no other alternative which will provide the care they require.

Older persons do have potentially an alternative in the Homes for the Aged which exist in most municipalities and counties in Ontario. Public and privately sponsored Homes for the Aged often include simple residential care for persons who are reasonably well, senile wards for persons who are mentally enfeebled, and quasi-medical wards for persons who are quite ill. The average age of residents in Homes for the Aged is said to be 82-84 years but again there is an insufficient number of beds for all applicants, long waiting lists in some municipal jurisdictions, and a desire on the part of administrators to admit those persons who will require the least care and thus are able to take care of themselves in substantial measure. This last proposition is apparently a thread running through all forms of residential service since their application requirements – and thus their exclusions – make it impossible for some applicants to be accommodated, even if the supply were greater than it is.

Under voluntary auspices there are many important residential services for the elderly in Ontario which take the form of Homes for the Aged and sometimes are quite significant institutions in terms of the quality and variety of services offered. The most notable of these is the Bay-

crest Centre for Geriatric Care in Toronto which has a home for the aged, a hospital, and an apartment dwelling/residence for couples and persons who are reasonably able to take care of themselves in their own housing accommodation. The Baycrest complex has been developed over nearly 25 years.

There are many minor alternatives of some importance which have been suggested for the accommodation of the elderly, including some which do exist in small supply in certain jurisdictions. Foster homes for the elderly have been suggested from time to time and in some of the larger urban centres are an activity of voluntary organizations. They require a voluntary acceptance by residents of their own homes, of an elderly person for both room and board, in return for which a foster care allowance is paid. Even if the amount of money is adequate, a great deal of dedication and caring is required and there are few families willing to participate in this activity.

The general problem of housing or residential services for older people is thus seen to be extremely complicated and fraught with both economic and social problems. There is an insufficient number of alternatives to continued residence in one's own accommodation as aging proceeds and health problems become more frequent. This is the other side of a coin in which the fact of insufficient supply of any form of alternative accommodation, with the possible exception of senior citizens' housing under Federal-Provincial auspices, is a basic fact of life. Nursing Homes, Homes for the Aged, foster home care, apartment/residence complexes, are all intelligent alternatives if they were in sufficient supply and if their organization and quality were at the highest or at least an acceptable level. Unfortunately this is not always the case.

Moreover, the problem of transference from one facility to another, mentioned previously, is constantly a worry to the older person and his family, and may result in an intensification of health problems leading at times to premature death. Adequate solutions to the problems of housing accommodation might go far towards alleviating the pressure on health care services. Nevertheless, the Ministry of Housing is potentially of the view that social and health problems are unjustifiably considered soluble in terms of shelter provision, with the enormous subsidies becoming the responsibility of one ministry exercising its function as the potential solution to problems under the jurisdiction of other ministries. This raises a significant question in inter-ministerial cooperation.

C) Alternatives to Current Service Delivery Systems

(1) Home Care Programs in Ontario

Two factors are most influential in explaining the development and expansion of home care programs. The first is the generally accepted principle that, where appropriate, it is better for a person to be treated or to convalesce at home than in a hospital or some other institution. The second factor is the expectation, in a period of economic constraint, that utilization of home care will result in substantial financial savings to the health care system because the average per capita per diem cost of the program is far less than the average per diem cost per hospital patient or institutional resident.

The basic stipulations for admission to the Ontario Home Care Program include: the Ontario resident must be covered by OHIP; a patient can enter the program only when his physician specifies that at least one professional health service is required, among, for example, nursing, physiotherapy, occupational or speech therapy. A minimum requirement for professional services is set in terms of the number of visits per month; for example, in the case of nursing, 3 visits are required. A person can enter the program from the community, without going to hospital; or may receive home care services after discharge from a period of hospitalization.

There are two other stipulations for admission; the home care staff must be satisfied that the individual patient has a suitable home environment (for example, an elderly person living in a single room may be an inappropriate applicant because of lack of facilities in the home or persons able to assist) and the individual concerned must also be unable to utilize alternative out-patient services provided at a hospital. When these criteria are met, home care services are provided so long as the patient's physician recommends utilization of the program. In turn, the physician continues to head the team "providing medical services in a planned program of comprehensive medical care at home". Participation of the patient is normally discontinued when no reasonable change in his condition may be anticipated, that is, the patient has reached a level of stability.

There are in 1978, 38 Home Care Programs in Ontario, each under separate administration. The majority of these programs are administered by local Health Departments; two are under the auspices of branches of the Victorian Order of Nurses. The program in Metropolitan Toronto is entirely autonomous under the supervision of a voluntary board of directors. Whatever the auspices, all home care programs are funded by the Ministry of Health.

As home care is understood today, it encompasses a very broad area of health and social services. In addition to the activities of the health care professions already mentioned, the physician may request social work therapy (personal, family, marital or group) and the services of homemakers. Up to 80 hours of homemaking service may be provided, in the first month, plus 40 hours per month thereafter, if recommended by the health care team.

In discussion with consultants the Task Force underlined the differences in the capacity to provide home care between large urban centres and smaller communities in Ontario. A difficulty lies in the availability of the skills required for home care. Nursing is not a problem because of the apparent present surplus of registered nurses; but physiotherapists and social workers are not plentiful, and occupational and speech therapists are quite rare. The problem of providing homemaker services is difficult to solve. The cost of homemakers ranges in the province from about $30 to $60 per diem.

It is assumed by the responsible community agency that a homemaker would spend about a half a day in a person's home at one time, but many people may require only an hour or two per diem. There is a further problem involving homemakers, specifically the question of which organization will pay for their services. In smaller communities there is the advantage that travelling time is short and that both the physician and other professionals may undertake home visits more frequently than is possible in the larger urban centres. However, there are great difficulties in delivering home care in rural areas.

On October 1, 1975, the Ministry of Health expanded the Home Care Programs throughout the Province to make physiotheraphy, occupational therapy and speech therapy available to residents of Nursing Homes and Homes for the Aged. At the same time the Ministry created three pilot projects – within the home care programs in Kingston, Thunder Bay and Hamilton – to extend the program to chronic care to qualified patients in their own homes. The aim was to determine the extent of utilization and the cost of including such patients in Home Care*.

The largest and longest established organization is the Home Care Program for Metropolitan Toronto, formally established in 1964.

* Ontario, Ministry of Health, *Report on the Evaluation of Chronic Home Care.* Mimeo. November 1977. pp. 1-2.

The program is funded by the Ministry of Health and uses its financial resources to purchase community services and for the coordination of these services in the delivery of care to patients. Home Care Co-Ordinators are located in 38 hospitals in Metropolitan Toronto, where they receive referrals from physicians, assess patients for ongoing treatment and with the cooperation of all hospital personnel arrange for the effective transfer of patients from hospital to home.

In its Twelfth Annual Report the Home Care Program for Metropolitan Toronto noted that community-initiated patients admitted to the program increased more rapidly in the 1970's than admissions described as hospital-initiated*. A community-initiated patient is defined as a person residing in his own home, a home for the aged or a nursing home at the time of admission. The Toronto group considers that the continuing increase in such referrals supports the belief that many people can be treated adequately in their own homes without admission to hospitals and that the Home Care Program has the capacity to process incoming referrals more efficiently†.

During the fiscal year 1976-77, the program in Metro Toronto admitted 11,891 patients, 59.1 percent of whom (7,025) were 65 years and older††. The percentage of patients over the age of 65 receiving services through the program increased by 14.7 percent in one year.

It is interesting to note that in the provincial program as a whole, in the same fiscal year, the proportion of patients 65 years and older was 49.3 percent. Community-initiated admissions throughout Ontario in 1976-77 amounted to 33 percent of all admissions to Home Care (28 percent from own homes, and 5 percent from homes for the aged and nursing homes).††† It would appear therefore that home care programs are significant resources for the care of older persons in their own homes, and in fact are devoting about one-third or more of their resources to such service.

* Home Care Program for Metropolitan Toronto. *Twelfth Annual Report*, 1975-1976. Toronto. March 1977, p. 4.

† Home Care Program for Metropolitan Toronto. *Thirteenth Annual Report*, 1976-77. Toronto. February 1978, p. 3. Despite a decrease in fiscal 1977, the Home Care Program expects an increasing number of referrals from the community in 1977-78.

†† *Ibid.*, p. 7.

††† Data supplied by Dr. R. M. King, Consultant on Home Care Program, Community Health Division, Ministry of Health.

In the provision of home care no assessment is made of ability to pay, since patients are by definition covered by OHIP. People are provided with the home services they require as they progress towards a treatment goal. They are discharged from the program when their condition has been stabilized, that is, when they have reached a maintenance level. In 1976-77, 91 percent of the patients in Metro Toronto required nursing services, 28 percent required homemaking services, 18.5 percent required physiotherapy services and 9.5 percent required occupational therapy. In terms of non-personal services, 66 percent required drugs, 43.6 percent required dressings and 16 percent were provided with equipment. On discharge more than 75 percent of the patients in 1976-77 required no further service. The remainder did require public health supervision, physiotherapy, homemaking, social work, occupational or speech therapy. These persons were referred to community agencies that normally provide such services within their capacity.

For 1975-76 the Metro Toronto Home Care Program estimated its average per diem cost at $12.01, an increase of about 15 percent from $10.45 in 1974-75. Preliminary figures for Metropolitan Toronto for 1976-1977 indicate a per capita per diem cost of $7.55. There has been a great increase in the number of days of care without a proportionate increase in provincial funding.

The per capita per diem cost for the three pilot projects (Hamilton, Kingston and Thunder Bay) for the fiscal year 1976-77 was $9.44 for the total patient care load*. It was not possible to obtain a breakdown between standard care and chronic care patients, but for the first half of 1977-78 the cost for chronic home care in Hamilton was estimated at 60 cents less per diem than for active home care. In the absence of additional information concerning accounting procedures the Task Force believes that, despite the lack of comparability from place to place, the figures are very reasonable, suggesting important savings over other forms of service delivery.

The Ministry's first evaluation of chronic home care was released in late 1977.** It recommended that the Chronic Home Care Program continue in the three pilot projects for an additional 18 months. It was not possible to carry out an adequate evaluation during a time

* Conversation with Dr. R. M. King, Consultant on Home Care Program, Ministry of Health, March 14, 1978. The data are as precise as possible but not necessarily comparable from program to program.

** Ontario. Ministry of Health. *Report on the Evaluation of Chronic Home Care.* Mimeo. November 1977. pp. 4-6.

of rapidly increasing case loads. Now that case loads had stabilized, the second recommendation called for a more extensive evaluation for a 12-month period. In addition the study recommended that the Home Care Information System be revised to provide more specific data concerning patients.

As far as elderly people are concerned the Report was significant. Chronic Home Care is clearly a service for the elderly – 72% of CHC admissions were 65 years of age or over compared with 47% of Acute Home Care patients. The average length of stay in the latter program was 25.6 days; in the Chronic Home Care Program, it was 56.7 days. Nevertheless, patients in both forms of home care received a similar average number of visits per month: 7 nursing visits, 4 therapy visits, and 34 hours of homemaking service.*

In terms of cost effectiveness the results of the study indicate that chronic home care is more economical than institutional care on a per-patient basis. Nevertheless, it is clear that the costs of extending the program across the Province would be very significant.** The Ministry is equally concerned about the impact of such expansion on the "rest of the health care system", particularly in the context of the objective of home care as a substitute for institutional care.

After careful consideration following its meetings with several consultants the Task Force recommends:

Recommendation 32. *THAT the Ministry of Health expand Home Care Programs to provide better total care in elderly persons' own homes, in order to prevent unnecessary institutionalization; and*

Recommendation 33. *THAT the Ministry of Health make Home Care Programs more accessible for people in need of long term care, on the assumption that the further evaluation of the pilot projects offering home care to chronic patients in Hamilton, Kingston and Thunder Bay, supports the expansion of Chronic Home Care.*

Recommendation 34. *THAT the Ministries of Health and Community and Social Services jointly assess the problem of providing home care in rural areas and take appropriate action.*

* *Ibid.*, p. 6.

**Hon. Dennis Timbrell, Ministry of Health. *Statement* concerning the Report on the Evaluation of Chronic Home Care, to the Legislature of Ontario, November 24, 1977. Mimeo. pp. 1-4.

Recommendation 35. *THAT any decrease in institutional costs resulting from the development of community services must be accompanied by the transfer of appropriate resources to provide adequate support services in the community through the Ministries of Health and Community and Social Services working in cooperation.*

(2) Placement Coordination Services (Assessment and Placement Services)

Although the great majority of Ontario residents 65 years of age and older (perhaps 9 out of 10) literally live in their own homes and in their own communities, there is increasing concern about the most appropriate utilization of institutional facilities which exist in various forms. Not only is institutional care costly to the total community by virtue of public expenditures on homes for aged, nursing homes, chronic care facilities, and the like, but there are both social and economic costs involved to the individual patient and to his family. The social disruption involved in moving a person from his own home to any form of institution, including an acute hospital, may be dangerous to the health of an older person and indeed the literature demonstrates that such moves may be fatal. It is thus of very great concern that each person placed in an institutional setting is in fact in the most appropriate setting for him. This is not a matter, the Task Force learned, to be accepted at face value.

At any one time in many Ontario communities, a substantial proportion of persons in specific institutional facilities ought to be in some other form of facility. In one study, it is concluded that perhaps a fifth* of all those in institutional care at the time of research, should not be in any institution whatsoever, since they appeared to be quite capable of taking care of themselves in their home and in their own community.

These concerns have led to the first significant Assessment and Placement Services in Ontario. The most notable programs to date are in place in Hamilton, Ottawa and Thunder Bay. It is understood that the latter two are modifications of the Hamilton model. There is also an important development in coordination in London. These programs merit some considerable exposition in this report.

In 1971 the Hamilton District Health Council established an Assess-

* R.D.T. Cape et al., "Square Pegs in Round Holes", CMAJ, Vol. 117, December 3, 1977, pp. 1284-87.

ment and Placement Service.* The project was funded by the Ontario Ministry of Health and began operation in September 1971. The Service was recommended after study by an Extended Care Committee which felt strongly that a coordinating body should be formed "to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations concerning the appropriate programs or levels of care for the development of the individual's assets and potential".**

A medical consultant is the senior professional person, and provides professional back-up to the nurse counsellors, in the Assessment and Placement Service. He also works as Coordinator of the Geriatric Program of the District Health Council and negotiates with the institutions in the community for improving the availability of accommodation and resources for elderly persons. The A.P.S. must be well-informed about the services and facilities in the community and assist in directing the patient to those most suited to his needs, after an evaluation of the assessment.

The assessment is based upon a methodological tool which provides the necessary information for appropriate recommendation. Three categories of information: demographic, medical, and functional capacity, are explored in substantial depth. The demographic and functional capacity data are provided by a social worker-nurse team for the applicant who is hospitalized, and by a public health or visiting nurse to those applicants who are at home. The medical information is provided by the applicant's personal physician.

"Assessment" is defined as "the evaluation of the needs, capabilities, and assets of the applicants from the information supplied by physicians, nursing and social services and other health professionals"†. Placement involves necessarily the identification and recommendation of the most suitable program or programs to meet the applicant's needs and develop his potential and capabilities. It must also include facilitation of the movement of the applicant to the site of the program or vice versa.

The Assessment and Placement Service indicates in its latest annual report that two general problem areas have been identified:

* The formal title is now Assessment and Placement Service of the Hamilton-Wentworth District Health Council.

**Assessment and Placement Service, Hamilton-Wentworth District Health Council, *Annual Report 1976*, p. 3.

† *Ibid.*, p.4.

(a) difficulties health professionals have in assessing specific needs and responding to them,

(b) difficulties that exist in the provision of appropriate services and programs for certain groups of people with special problems.

One of the main deficiencies in the system which has evolved is that it is voluntary on the part of the institutions in the community. A nursing home, for example, may refuse to take a particular patient because he is incontinent, even though it is the best situation in the opinion of all of the professionals involved. The Placement Service has no control over matters of this kind; individual institutions have their own rules to which they often adhere rigidly.

It is noteworthy that the Hamilton-Wentworth Service has a growing waiting list of persons awaiting placement from both acute treatment hospitals and from their own homes in the community. On a year to year comparison the number in hospitals awaiting placement increased from 134 in 1974 to 251 in 1976; the number in the community awaiting placement increased from 218 in 1974 to 328 in 1976. The facility required most often is a nursing home, followed by the need for chronic hospital accommodation and homes for the aged in that order*.

As a result of the work and study of the Assessment and Placement Service, a number of deficiencies in the health care system have become clearer. Three particular weaknesses have recently been explained by the medical consultant and chief administrator:

(a) some referrals coming from acute care hospitals appear to indicate that the person had been slowly declining at home, and had had very little assistance or encouragement from any health service until an acute social crisis occurred that precipitated admission to hospital. The term "social crisis" implies that there is reluctance on the part of the family to continue care and the return home of the elderly patient is often strongly resisted even if the individual improves greatly.

(b) many people requiring extensive nursing care wait in acute and chronic care hospitals for accommodation in nursing care facilities. The problem does not seem to be a deficiency of such beds but rather an inappropriate use of them. The available places in such facilities appear to be taken by people needing much less

* *Ibid.*, p. 18.

care and who could be managed at home if sufficient community services existed.

(c) community support programs such as Home Care can be effective in helping people stay at home but the requirement for service and the effectiveness should be evaluated for cost control.

The Assessment and Placement Service thus has a dual role. It is a clinical service organization providing advice and guidance in professional management, and it is a fact-finding organization that contributes to evaluation of services and to planning.*

The concept in London, Ontario is somewhat different. The difference lies in the approach to coordination and assessment. There is no formally constituted Assessment and Placement Service in London, but there is a Coordinator, who is in fact the Professor of Geriatrics, Faculty of Medicine, University of Western Ontario. In London, therefore, the coordination is carried out from the University, using a cooperative approach in which assessment and treatment consultation is available to practitioners on request; whereas in Hamilton, the District Health Council authorizes the Coordinator to investigate and recommend methods of correcting any deficiencies in the organization or provision of services. The major difference in approach, therefore, seems to be in the authority granted to coordinators.

An important and interesting research project was carried out in London in the summer of 1976. The research objective was an examination of the extent to which each individual in a sample of elderly people was placed in an institution which is most suitable for his needs. In that community in which there are approximately 2,350 beds for care of the elderly and chronic sick (for an elderly population of approximately 25,000, 65 years of age and over) a random sample of 736 persons was evolved by including every third individual on an alphabetical list of residents and patients in each of the facilities surveyed.

The system of Patient Care Classification adopted by the Ministry of Helath of Ontario in 1975 was utilized as the basis for assessment of the individual's current and most appropriate situation. The traditional definitions of "residential", "extended health care", and "chronic care", were adopted in the research. The basic assump-

*J.R.D. Bayne and J. Caygill, "Identifying Needs and Services for the Aged", *J. Am. Ger. Soc., Vol. 25, June 1977,* p. 264.

tions were that "residential" is the type of care provided by Homes for the Aged; "extended health care" is the type of care usually found in Nursing Homes; and "chronic care" is the type of care available in Continuing Care Hospitals. Within the overall objective of the survey, that is to learn whether the available beds in the different institutions were occupied by the type of case for whom they were intended, there were two specific questions posed by the research:

1. Is the proportion of beds of each type appropriate for the needs of the community?

2. Is each individual in the institution which is most suitable for his individual needs?

A careful assessment was undertaken of the mental status, hearing, sight, ambulation, record of falls, activities of daily living for each subject in the large random sample. The findings were startling.

In terms of the overall needs of the London, Ontario community the major findings were: that London needed at the time of the study, about 100 fewer beds in Continuing Care Hospitals but 70 additional beds in Nursing Homes, and 40 more in Old Age Homes*. One particularly significant finding was that 62 individuals (8 percent of the number surveyed) achieved the maximum score in the activities of daily living examination, had a normal mental status and no clinical problems. There was no apparent reason, in the view of the researchers, why those people should have been in any institution at all**.

As far as appropriate placements were concerned, the individual assessment of the subjects' needs resulted in a decision by the survey team which was compared to the actual placement at that time. As far as Homes for the Aged were concerned 71 percent of 224 subjects in such homes were considered to be appropriately placed. To state the matter another way, about 30 percent of those residing in Homes for the Aged would have been more appropriately placed in Nursing Homes or Chronic Hospitals. The situation was even more out of line in Nursing Homes. The survey team considered that about 46.3 percent of those in Nursing Homes were appropriately placed; in short, more than half of 190 subjects in Nursing Homes at the time of the research should have been placed in

* R.D.T. Cape et al., "Square Pegs in Round Holes", (London, Ontario) mimeo. pp. 6-7.

***Ibid.*, p. 8.

Homes for the Aged or Chronic Hospitals. Among those in Chronic Hospitals, 185 subjects were considered appropriately placed, that is, in approximately 51 percent of the cases. Nevertheless, almost half of those persons in Chronic Hospitals were considered to require Nursing Homes and Homes for the Aged, respectively. In this tabulation 18 percent of the subjects who were in "special care beds" were excluded*.

The researchers warned that the findings of one study should not be overemphasized. It would indeed be unfortunate if some 30-50 percent of those persons in Ontario resident in institutions providing care for the elderly, were inappropriately placed. Nevertheless, a similar investigation produced approximately the same type of result in Kingston, Ontario**.

The researchers concluded that there are four possible reasons for the high level of inappropriate placement. These are: (1) the time delay between the assessment of an individual's needs and the actual move into an institution; (2) few patients remain, over a prolonged period, in the same clinical state; (3) the well-known fact that moving elderly patients from one institution to another can be very upsetting to them and even fatal; and (4) far too many applicants for placement are created by crisis admission to an acute hospital.

The Task Force concluded after careful study of the evidence, that there is a desperate need for assessment and placement services throughout Ontario, with some authority to insist on the proper placement. It recognizes that the matter of authority raises important questions. Can the view or decision of the APS be made mandatory for the patient, whatever his personal choice, or for the nursing homes, which are privately operated?

Finally, the Task Force concluded that when assessment and placement services are established there should be an educational program, perhaps in the form of a continuing/occasional seminar for health workers in the various geographical areas, to inform them of procedures which have been developed and to educate them in the completion of assessment forms.

* *Ibid.*, Figure 8.

**A. F. Kraus, R. A. Spasoff et al., "Elderly Applicant to Long-Term Care Institutions. The Application Process; Placement and Care Needs" (Kingston, Department of Community Health and Epidemiology, Queen's University) published in the *Journal of the American Geriatric Society*, vol. XXIV, 1976, pp. 165-172.

It is recommended:

Recommendation 36. *THAT the Ministry of Health, in cooperation with the Ministry of Community and Social Services, establish Placement Coordination Services, with relationships to District Health Councils and municipal governments, for each area, district or region of the Province, to achieve the following purposes:*

- *To act as a knowledgeable focal point to permit advanced planning for any move from home to institution or between institutions;*
- *To coordinate the care of the elderly person and ensure that people are placed in the best level of care and location to suit their needs;*
- *To avoid unnecessary or premature institutionalization by ensuring that all community resources have been considered.*
- *To ensure that a patient is moved through levels of care, with ease and at the appropriate times;*
- *To ensure that no person is discharged from any institution until the family or other organization has had adequate time to prepare for the discharge.*

Chapter 4:
Organization of Health Care Delivery

A) The Problem of Divided Jurisdiction

The provision of services to elderly people is a large and complicated problem in our country. The Federal Government has jurisdiction in the important area of income maintenance and shares with the provinces in the provision of social assistance, as well as in the financing of a variety of personal services. Nevertheless, most of the services needed by our citizens, whatever their age, are under the constitutional authority of the provinces. Health, social services, recreation, education, transportation, and a variety of less well recognized needs are within provincial jurisdiction. A consideration of the multiple requirements of elderly people, or persons in any specific age group for that matter, makes it clear at once that the total requirements of individuals and families cannot be met within one single Ministry or government department in a province as large and as populous as the Province of Ontario.

In most of these respects elderly people are not different than other persons in their fundamental requirements. Everyone in Ontario requires health services, social services, and a variety of personal services which are provided under the auspices of different governmental organizations. In the case of the elderly, however, it is more apparent than in the case of younger age groups, that the impact of inadequate services in fields other than in health has an important influence upon health itself.

It has been shown earlier in this report that Home Care is not simply the provision of specific medical services within the home but depends substantially for its success upon the availability of other services which can be described as "social" – for example, the services of homemakers, of occupational therapists, social workers, and a variety of community services. Moreover, the lack of availability of transportation facilities may force an older person to remain in his home, to draw further within himself, and thus may lead directly to a requirement for institutional care. Among the elderly mobility is essential to a degree well beyond that affecting the well-being of most other age groups. Lack of mobility may lead directly to health problems, mental as well as physical in their manifestation.

The Task Force recognizes therefore, that its finding of divided and overlapping jurisdiction in the provision of services to the elderly, was neither surprising, nor unknown previously. The problem arises in almost

every attempt to provide a better level of health care and "quality of life" for elderly people. Many examples can be cited, but two are particularly illustrative: nursing homes are at the present time under the ultimate jurisdiction of the Ministry of Health. Homes for the aged, on the other hand, are under the supervision of the Ministry of Community and Social Services. It must be clear that the provision of residential care in homes for the aged should have a large and increasing medical or health component.

A second example would be the entire matter of community centres and recreational facilities. These facilities clearly have a social component but most of their funding, except for occasional grants from the Federal New Horizons Program, come from the Ministry of Culture and Recreation in Ontario. The Agencies sponsoring such centres, may however, be financed partially by the Ministry of Community and Social Services.

There is no doubt that there is confusion, not only in the minds of the general public, particularly the families seeking the best health and related services for their elderly relatives, but in the minds of government employees themselves. There is, for example, the possibility of responsibility being transferred both back and forth in the case of sequential progression in care and facilities. An individual may be in an acute general hospital, funded by the Ministry of Health, but an adequate assessment of his appropriate future placement suggests that a Home for the Aged is most appropriate. The latter facility is under the jurisdiction of the Ministry of Community and Social Services. It is not easy for the elderly person to understand these complications nor for his family to make the necessary applications, to explain delays in transfer, and to find interim arrangements while the individual concerned awaits the most appropriate residential facility.

It was pointed out, in reporting the research project undertaken in London, Ontario, that during this period of waiting there may be further medical regression and ultimately, should the former appropriate setting become available, it may no longer be appropriate because the level of care now required suggests that a Nursing Home or a Chronic Hospital is more appropriate. The reverse progression may also occur, specifically, that persons in Nursing Homes may occasionally be able to return to their own community. The appropriate facility would be a Senior Citizens apartment which falls under the jurisdiction of the Ministry of Housing in Ontario, whose agents are more than 50 local housing authorities who appraise the needs of applicants, select tenants, administer the rental and manage the physical facilities to be occupied by reasonably well, ambulatory older persons.

An additional complication arising from divided jurisdiction is evident when consideration is given to the criteria whereby care is provided for certain elderly persons. In the case of the Ministry of Health, the basic criteria must be the health needs of individuals who are considered elderly, although the same criteria are applied to members of other age groups. In the case of the Ministry of Community and Social Services and to a substantial degree in the case of public housing administered by the Ministry of Housing, the basic criteria are income and assets. While it is true that the Ministry of Housing does not draw maximum income limits governing the admission of individuals and families to public housing accommodation, priority must be given to those in greatest need of accommodation, and those with the lowest income clearly have a higher priority for accommodation than persons who presumably can find accommodation in the private rental market. Similarly, certain income maintenance programs and other services administered by the Ministry of Community and Social Services require that a test of needs (or means) involving an examination of income and assets, must be administered before determining the eligibility of an applicant for such services. Still another example is the varying age for availability of services in the various Ministries, as already mentioned.

In view of the important and unfortunate consequences of divided jurisdiction in the provision of services for the elderly, the Task Force recommends:

Recommendation 37. *THAT the Minister of Health impress upon the Government of Ontario the urgent need to develop a new coordinating mechanism for services for the elderly, perhaps reporting to the Provincial Secretary for Social Development, with at least the following direct functions:*

(1) to identify the requirements for health, social, housing, educational and recreational services throughout the province;

(2) to coordinate all regional (local) health and social service programs provided for the elderly;

(3) to establish standards and evaluate such health and social service programs;

(4) to provide consultation and support services for the offices at the regional level; and

Recommendation 38. *THAT the Government of Ontario delegate responsibility to the regional or district health council level throughout the Province to:*

(1) encourage the development of essential health, social, recreational and educational services for the elderly at the level of the community;

(2) develop and administer an information service about health and social services for the elderly within its geographical jurisdiction;

(3) facilitate volunteer programs for and by the elderly to strengthen the capacity of older people to live at home in the community.

B) The Problem of Planning and Coordination

There is clearly a strong requirement for planning and coordination of services for elderly persons in Ontario in consideration of their needs at the present time, their cost to the health care and social service systems, and the future projected increases in their numbers (cf. *supra* Chap. 1). Even if there is no increase in the rate of illness, or institutionalization, there is bound to be nearly a doubling of persons requiring social and health services, recreational services, special transportation facilities and a host of requirements which can be met only to a limited extent by the private means of our elderly citizens.

Such planning must occur within and between Ministries of the Government of Ontario and at the local or municipal level by means of coordination within the regional governments and district health councils. No matter how much planning and coordination on paper exists there will remain the problem of making plans effective. This will require a significant change in the attitudes of public servants at the municipal and provincial levels towards the elderly. On the one hand, it is desirable not to separate out older people and to insist that they are "special cases" with needs unlike those of the general population; on the other hand, older people do have special requirements, less essential to the well-being of younger people, and these must be provided within programs designed to meet their needs.

To make plans effective will require a series of concerted steps which in the view of the Task Force are all too often, in the late 1970's, overlooked or neglected. In the first place, although we know a good deal about elderly people in our society, there must be continuing study to identify needs, the number of persons likely to require services, and the priorities which can be assigned to existing services. Moreover, government must set out its policy goals for services to the elderly over the next quarter-century. Only in this way can priorities be established which will guide government in allocating resources, in strengthening existing services which must be expanded or in creating entirely new

services. If we are not prepared for the very large increase of the elderly expected by the turn of the century, then we will be totally unable to cope with the even more massive subsequent increase when the post-war baby boom reaches old age.

These actions on the part of both public and voluntary agencies, preferably in partnership, will require a system of guidelines stemming from policy directives. Guidelines, as the Task Force visualizes them, will establish the required financial support so that services can be expanded or initiated as the people of Ontario face the impact of a future society in which the number of persons over 65 will outnumber the number of persons under the age of 20 for the first time in our history.

An attempt at coordination of health and social services is underway within two of the eleven regional governments in Ontario, specifically the Regional Municipality of York, and the Regional Municipality of Waterloo. It is assumed that coordination may be possible of attainment when there is one overall direction of both health and social services, rather than Commissioners of Health and Social Welfare, respectively. It is too early as yet to know whether these efforts at coordination within public administration will achieve the necessary coordination on behalf of disadvantaged persons, including needy elderly persons. It is noteworthy, as well, that in Metropolitan Toronto, the first and largest regional government in the province, there is a Commissioner of Social Services on a Metro-wide basis, but jurisdiction over the health services remains in the hands of the City and five Boroughs within the local Departments of Public Health.

In certain provinces in Canada the Ministries of Health and Social Services have been combined under one Cabinet Minister; in other provinces they have remained separate. In some cases the situation which was separate at one point has been combined, when new governments have come to power. In part there is a conviction in some provinces that there are simply too many problems in each of the several fields of service to combine them in one Ministry.

There will have to be as well, an orgnizational structure developed within government, and in partnership with voluntary agencies, to assume responsibility for the planning and coordination of services for older people in Ontario. Such a structure may be defined as a responsible body of planners, implementors, and evaluators, headed by a person clearly identified as the senior person in the field of aging in the province. Until now the Province of Ontario has had a Senior Citizens Branch and Office on Aging (a combined agency) within the Ministry of Community

and Social Services. The Task Force has recommended that the provincial government establish a special agency, which would be completely independent of any existing Ministry or Department, but perhaps responsible to the Provincial Secretary for Social Development.

As programs and services develop and expand to meet the needs of older persons in Ontario during the last two decades of this century and into the twenty-first century, they must be carefully examined and evaluated, both in quality and quantity. There is a danger, in the view of the Task Force, that the types of programs and services developed to assist older persons when they numbered only 5 or 6 percent of the population will be considered satisfactory when the proportion of the elderly is double or triple that of the first half of the twentieth century. No one knows at the present time whether existing services, including those most recently established will continue to be appropriate; similarly no one knows whether such services will be utilized by the elderly people of the future.

It can be anticipated that older Ontarians of the future will differ in many ways from those who reached age 65 during the first 75 years of this century. In general, a greater proportion of them will have had more income during their life time than their predecessors and could be described as relatively affluent. More elderly people in the future will have had post-secondary education and professional careers rather than the working class backgrounds of the vast majority of retired persons and housewives in our current experience. They will have travelled more; they will have had more varied life experience; they may be interested in new programs of service to the community, of services to groups like themselves, of volunteer work with those less fortunate; and they may develop, through programs of adult education, entirely new careers on a part-time or full-time basis, whether paid or unpaid. In short, older people of the future will be different from those of the past and this alone necessitates careful evaluation of the programs and services allegedly developed to meet their needs.

In order to overcome the present lack of planning and coordination of services to the elderly the Task Force recommends:

Recommendation 39. *THAT the Government of Ontario provide adequate and flexible funding at the regional level for services to the aged, to include health, social services, housing, and other programs.*

Recommendation 40. *THAT regional authorities be given much more direct responsibility for the coordination, and in some cases supervision, of community health and social services (e.g. nursing homes,*

homes for the aged, and lodging homes for the elderly) in areas under their jurisdiction.

C) The Problem of Attitudes

The attitudes of the people in Ontario in general toward the elderly in their midst are not positive, in the considered judgment of the members of the Task Force. In part, although not entirely by any means, this is a result of the emergence of the so-called "youth culture" dating from the mid-1960's. By that time the demographic consequence of Canada's high birth rate after 1944 was a population in which more than 42 percent were under the age of 20 years and 50 percent were under the age of 25 years.

These population data, by themselves, did not constitute a youth culture but in a free market capitalistic society, many industries and marketing activities were directed toward the young. These were the persons increasing most rapidly in numbers, with money to spend in a growing economy after 1962, and more interested in entirely new modes of living than their parents and their grandparents. In this socio-economic atmosphere the steadily but slowly increasing number and proportion of persons over age 65 was scarcely noticed. Moreover their financial impact in terms of federal and provincial budgetary support for income maintenance and other programs was a small fraction of a rapidly increasing gross national product and governmental expenditures.

By the late 1970's the situation has changed drastically. The sharp drop in the birth rate throughout all the Canadian provinces after 1960 has meant that the proportion of young Canadians (under 20) has declined sharply and is approaching 35 percent. At the same time attention has been directed to the increasing numbers and proportion of over 65's, over 75's and the old-old members of our total population. The concurrent incidence of inflation and unemployment – the former hitting particularly persons on low or relatively fixed incomes, such as the elderly, and the latter hitting particularly the age group 15-24 years – has created not merely concern, but resentment.

There is a belief among many young and middle-aged people that older persons are holding jobs from which they should retire earlier and thus make more work available for other people. Although there is no evidence that relatively young and inexperienced persons (who comprise a major portion of current unemployment in Ontario) could take over positions vacated by those retired, this fact is not widely understood. The Task Force understands the aspiration of persons in middle years and middle management to achieve earlier than normal promotion to senior positions.

Much publicity has been given in the late 1970's to the increasing cost of retirement pensions in both the private and public sector, not merely because of increased numbers of persons living longer lives, but because of the impact of inflation upon their purchasing power. Ontario's population aged 65 and over qualify for substantial financial support beyond the universal Old Age Security Allowance if they are in relative poverty, together with significant health and social services. A federal-provincial Guaranteed Income Supplement and the Ontario GAINS (Guaranteed Annual Income Supplement) program for those in the most stringent financial circumstances ensure that, early in 1978, an elderly resident will have not less than $300. per month; a married couple will have almost $600.

An elderly couple in Ontario may now qualify (subject to certain residence requirements) for a guaranteed annual income approaching $7,200. In addition both persons are enrolled in the Ontario Health Insurance Plan and receive most prescription drugs, all without direct cost. Other services include reduced public transit fares. In short, given reasonably-priced housing accommodation, an elderly couple should be able to maintain a modest but adequate standard of living in this province. A single elderly person, however, may have serious problems in ensuring an adequate living standard.

In the view of the Task Force negative social and economic attitudes toward older persons, real as they may be, should not be exaggerated. They do call for concerted action by public and voluntary authorities to attempt to change attitudes. In the first instance, the Task Force suggests that educational programs are required within the earliest educational levels in Ontario. It is, in another connection, a common complaint that young people do not understand the urban industrial society which has developed rapidly since the end of World War II. It is in this society, with urbanization likely to reach near-totality by the end of the century, that many more old people must live, and it is about this society that young people must be educated. They must know who lives in the society, the services they need, the method by which such services are provided and the approximate cost thereof. They must understand that every elderly member of the society who receives benefits has contributed in his past to those who preceded him and for the benefit of those who follow.

The Task Force is not suggesting that it will be possible to "convert" a group of persons who feel some resentment toward those in the society unable to function without the assistance of public or voluntary programs. The people of Ontario will not suddenly become "nice" to

elderly people. Too many of them have already experienced situations in which a lovable older father or grandfather has changed to an apparently demanding, irritable person who requires their assistance from time to time, perhaps with the so-called "activities of daily living". Too many of them, similarly, have experienced situations in which the "kitchen-children-church" grandmother is no longer able to function without the services of a part-time or full-time homemaker. There are emotional strains upon the children and grandchildren of elderly persons and there are financial strains.

What the Task Force hopes for and recommends is a series of programs both within formal and informal educational networks, designed to educate and to some degree change the attitudes of younger people and the general public toward the elderly and their requirements.

D) The Problem of Institutional/Community Care

The long struggle between the alternative of care for disadvantaged or ill persons of whatever age in the community versus institutional care, plays a substantial role in shaping society's attitudes toward elderly persons at this time in our history. In the 17th and 18th centuries the local parish or municipality in the United Kingdom and in British North America was responsible for the care of persons in whatever age group, disadvantaged through every possible risk from birth defect to the infirmity of old age. By the 19th century, however, it became law in the United Kingdom that persons who sought "relief" by virtue of their disadvantage, were required to enter an almshouse, the prototype of the institutions of the 20th century. In these almshouses there were literally "lumped together" retarded children, orphans, medically indigent and mentally ill persons, and older persons for whom there was no one to care. By the late 19th century each county in most of the provinces and states in Canada and the United States had built a "county farm" or "county home" colloquially known as the "poor house", specifically for elderly persons who could not remain in their own homes and for whom life in the community appeared impossible.

The vestiges of this system continue to plague us in our attitudes towards the most appropriate care for elderly persons in a rapidly urbanizing society. This problem underlines the significance of the development of placement coordination services to determine which person requires which form of institutional or community care. Since the extended family has disappeared in Ontario with the exception of certain ethnic groups, the families of elderly persons very often assume that the

best solution to the care of an elderly relative is a placement in an institutional setting, and they are not particularly discreet in their selection – any institution will suffice so long as the problem of continuing care in the community is lifted from their set of responsibilities.

This is not to deny that institutional care for specific categories of persons, as defined by their health and social profiles, may be the most desirable setting. Some elderly persons are unable to function in their own homes and/or in the community and should enter a more sheltered form of residential care. The unfortunate aspect of the present situation, which must be underlined, is the inappropriate placement of persons in institutions providing care which is not required by the elderly individual, or, alternatively, placement in an institution which does not provide the kind or degree of care which the individual resident does require.

The problem with which the Task Force was confronted by many of its consultants rests in the fact that institutions in Ontario are prone to "high grade" their admittees, that is to say, they attempt to choose only those who will provide the least potential difficulties or appear to require the least care. In several consultations the Task Force was informed that many Homes for the Aged want only "the cream" among their numerous applicants; that is, that admission procedures favour those who are ambulatory, self-sufficient, and presumably might very well remain in the community.

Similarly, many nursing homes, which are designed to provide at least one and one-half hours of nursing care per patient per diem, are said to be reluctant to admit persons who are likely to be troublesome, no matter how that term is defined. The Task Force would support Recommendation 16 of the Ontario Council of Health report, "The Distribution of Hospital and Nursing Home Beds in Metropolitan Toronto", March 1977: "We recommend that Nursing Home costs be analyzed in detail for the purpose of developing an effective reimbursement system which reflects the actual nursing care load."

There is a real danger that the "sick-old" may be barred from various facilities which exist to provide the long-term residential care they require. The Task Force is aware that these anomalies may be stimulated by the funding arrangements for various types of institutional care. The patient admitted to an acute care hospital and to a chronic care facility does not share directly in the costs. On the other hand, the patient admitted to a nursing home pays directly, approximately one-third of the daily fee for standard accommodation specified by the Ministry of Health, and residents of Homes for the Aged are required

to pay a substantial share of the total cost of care. Recent reports* have pointed to these differential cost patterns and have recommended that whatever the form of institutional care, the resident should pay an appropriate share.

In this situation a major objective must be a set of programs designed to maintain persons in the community. These will range all the way from Home Care which involves a requirement for a specific professional health service as a part of the individual's needs, to simple tasks of home maintenance which could be performed by younger persons who are either trained and paid for such assistance, or serve as volunteers. It seems clear to the Task Force that there is a wide field of public or semi-public employment emerging, which will bring together the relatively unskilled and inexperienced younger persons who find it difficult to obtain employment in the technological society in which they find themselves, and the elderly who are simply unable with their own limited physical resources to carry on the activities of daily living. It is not suggested that the young members of the unemployed labour force become charitable volunteers only; rather, it is proposed that simple programs of training could provide a great deal of assistance to those members of a group which will soon become approximately one-fifth of the total Canadian population. The Task Force recommends, therefore:

Recommendation 41. *THAT the Minister of Health request the Minister of Community and Social Services and the Minister of Colleges and Universities to encourage the Colleges of Applied Arts and Technology to strengthen and/or develop courses designed to train students such as social service aides and health care aides to work with elderly people who require assistance to maintain residence in their own homes in the community; and*

Recommendation 42. *THAT the Ontario Welfare Council and the various Social Planning Councils and Volunteer Centres throughout the province work cooperatively to develop a curriculum for volunteers, including elderly people themselves, who wish to assist older persons to fulfil the requirements of daily living in the community.*

It is essential to emphasize once again, the pre-eminence of economic considerations in the controversy that has emerged between the advocates

*Ontario Advisory Council on Senior Citizens: *Recommendation* addressed to the Provincial Secretary on Social Development, March 31, 1977, in response to the Report of the Interministerial Committee on Residential Services; Report of the Joint Advisory Committee of the Government of Ontario and the Ontario Medical Association on *Methods to Control Health Care Costs*, Dec. 29, 1977.

of community care versus the advocates of institutional care. In considering economic factors many persons on either side of this difference in point of view, forget the essential requirement of adequate assessment of the needs of elderly, or other persons, and consider primarily the cost factors involved. The Task Force would stress that there has not been sufficient research to demonstrate that either insitutional care or home care programs do cost less than each other or that a substantial expansion of either type of facility will result in massive savings to the community as a whole. There is, however, no gainsaying the view that both community care and residential care are far less costly than residence in acute care hospitals.

E) The Problem of Specialization/Family and Community Practice

A specific problem exists in the practice of every profession treating the needs of elderly persons. Whether the discussion concerns the members of the health professions – medicine, dentistry, nursing, in particular or the social professions – social work, group work and recreation – the issue of treatment by specialists versus treatment by teams of varied professionals coordinated through a consultant geriatrician, is a very live issue.

In Ontario, in none of the health and social professions are the educational programs designed to create specialists, at least in the first degree program. Rather, educators have considered that the professional whose practice includes a substantial proportion of elderly patients or clients, should probably be prepared for such professional practice in internships, residencies, or in specialized clinical facilities. It has already been mentioned that although there are departments of paediatrics in the five health sciences centres in Ontario and in many acute and specialized general hospitals, there are no departments of geriatrics in the five medical faculties or in most acute general hospitals in the province.

The trend has been to appoint coordinators of geriatric education and service. Such appointments have already been made in the Health Sciences Centres in London, Hamilton and Kingston. The Task Force learned that an appointment of this nature is imminent in Toronto.

It is recommended:

Recommendation 43. *THAT the Ministry of Health make resources available to the five Ontario Universities which now maintain a Health Sciences Centre to establish a professorial chair of geriatrics within the Faculty of Medicine and a Department of Geriatrics, and*

Recommendation 44. *THAT at least one Ontario University with appropriate resources in the health and social sciences establish an Institute of Gerontology to strengthen teaching and to foster research in the broad field of aging.*

This issue therefore is not simply one of the professional practice but concerns as well the matter of professional education for health and social service practice. It was the conclusion of the Task Force, after discussions with many consultants, that most members of the health professions are exposed in their basic educational programs to little more than a few simple truths concerning the needs of elderly persons. Similarly, in the social service professions, there are very few courses concerned with the needs of clients in their later years, and certainly such courses that are available are elective for the students concerned.

The various professional disciplines therefore, seem to have accepted the desirability that physicians, dentists, nurses (there are some courses in geriatric nursing), social workers (there are some courses in gerontology and social work), physio- and occupational therapists, and others learn about the treatment of elderly people in their post-graduate experience or in their actual practice as full-fledged professionals. This is a very important question for the people of Ontario because the philosophy might be quite different. In the light of the numbers of elderly persons anticipated in this province within the next quarter century, it could be conceived that a very substantial increase is needed in the number of geriatricians, specialists in geriatric dentistry, specialists in psychogeriatrics, geriatric nurses, geriatric social workers, and specialists in occupational and physio-therapy with the elderly. This does not appear to be an acceptable view at the present time and the potential costs involved would be enormous if new programs specifically for the elderly, were to be mounted in the various professional disciplines.

The Task Force was informed that it might be better, in the practice of medicine, to train perhaps 25-50 geriatricians who would serve throughout the province as consultants to teams of various professionals in the health and social services, as required. This does not mean that the educational programs in medicine, dentistry, nursing, social work and the like, should not be strengthened with content concerning the needs of elderly persons, but it does probably mean that no vast increases in specialized facilities, academic appointments, and in clinical training facilities are anticipated, despite the fact that in future the clients of every profession are likely to be heavily weighted by those 65 years and older.

It is recommended:

Recommendation 45. *THAT the Universities of Ontario, within their Faculties or Schools of medicine, dentistry, occupational therapy, physiotherapy, speech therapy, nursing, social work, and health administration, ensure that all health professionals have adequate training in geriatric care and that, in addition, geriatric specialists should be available for further consultation.*

F) The Problem of Education Related to the Elderly

Professional Education

The obverse of the previous argument concerns the whole question of education for professional persons who will work with elderly persons in future. It has been emphasized that the aged already utilize a relatively high proportion of available health services of all types, and a growing number of health professionals are already involved in providing such services in both community and institutional settings, although their services are not limited exclusively to the aged. This reference applies to general practitioners, specialists in internal medicine, family physicians, and professionals working within family care clinics.

Nevertheless, the health care needs of the aged are often distinctly different and require in health and social service professionals, special skills and knowledge if these needs are to be completely identified and dealt with. Moreover, the body of information on aging and the illness and social problems that can occur in old age, is rapidly growing. There is however, a dearth of education, information and training programs related to aging and the health problems of the aged, although these are slowly appearing in response to need.

All students training in the health sciences and in the social services, and all practising professionals who deal with adults, should understand the impact of the aged on such services and gain experience in the organization and coordination of services to meet the needs of the aged. Professionals in the health services, from their student experiences onward, should be trained in the assessment of the complex needs of elderly persons, should learn to interview and to examine, and to carry out investigation and treatment appropriate to the special requirements of their clients. They should learn to share information with other disciplines and to work as a team to the benefit of each patient. In the training of such students there should be adequate supervision by persons experienced in working with the elderly so that students can gain clinical experiences and meet older persons with all types of problems.

One objective of such educational content (and, perhaps, special educational programs) must be to increase the number of professionals specializing in work with older persons, where shortages have been clearly recognized. In the previous discussion within this report, shortages were noted particularly in nursing, physio- and occupational therapy, and social work.

Education for Secondary and Post-Secondary Schools

This must mean that available information should be included in course material for *all* students, where appropriate, beginning with secondary schools and including colleges and universities. Such subjects as cell biology, growth and development, health and hygiene, sociology and social aspects of aging, demography and geography, appear particularly important. Such basic understanding for all who proceed through Ontario's educational system, will enable people in future to forecast their own and society's future problems and needs, and take action to preserve health. Moreover, they will have the motivation to work toward the reorientation of health services in the direction of prevention and on-going support.

It is reasonable to propose that all students in health sciences and social sciences in colleges and universities should be expected to gain an understanding of aging in humans and its effect on individual behaviour and social structures. In the health sciences, students should understand the effect of aging on cells and tissues and on mental and physical functions, and should understand the diseases and psycho-social phenomena that are associated with aging. In the social sciences, students should understand the social implications of increasing proportions of elderly persons in the society, the economic implications of programs of income maintenance and retirement provisions, and the political implications of substantial groups of voters over the age of 65 concentrated in specific urban centres and within specific constituencies.

It is recommended, therefore:

Recommendation 46. *THAT the Ministry of Education and the Ministry of Colleges and Universities ensure that information on aging and its effects be provided in educational curricula for students in secondary, post-secondary and university programs in Ontario.*

Education for Para-Professionals

The Task Force would emphasize in addition, that there is a substantial opportunity for para-professionals and persons at the technician level to work with older persons in enabling them to meet those basic functions

which constitute the elements of daily living.

It is recognized that these opportunities may not appeal to a great many persons, but among young persons now seeking post-secondary educational opportunities within Colleges of Applied Arts and Technology, there are many who would find the role of Case Aide to elderly persons a satisfying and useful experience. It is not visualized that one person would serve just one older person but would have a case load of perhaps 15-25 persons to be visited on the average once a week. At this time of constraints in educational resources and reluctance to begin new programs it is conceivable that programs in the Ontario CAAT's such as courses in the Social Services, could be adapted by adding content with respect to elderly persons.

There remains the further question of the employment opportunities which must be available at the conclusion of such diploma courses and this is a problem for the Ministries of Community and Social Services, Labour, and Health, to work out. It may well be that subventions to existing community agencies in the field of services to the family and to the elderly could be supplemented to enable employment of a few persons in each location. There is the additional problem of developing a career progression for young para-professionals who choose this type of work. The Task Force offers no solution to this problem pending the development of special educational programs and employment opportunities in the first instance.

Continuing Education and Consultation

Vocational requirements have a number of facets which should be given consideration; each relates to different elements of the present system of meeting the needs of elderly persons. There are already a good many persons in the health services professions and in the social services, working with elderly people or interested in doing so. Educational opportunities and specific information must be made readily available to such persons – who are already practising professionals – through courses, lectures, workshops, audio-visual materials, books and lectures by informed specialists, as well as access to informed consultants.

The interest of the Task Force rests in high quality care which should be promoted in every area where elderly people are treated. To achieve this objective, advice and back-up resources must be readily available and within each health district the coordination of resource personnel and services must be accommodated. Such coordination might be handled through one individual appointment or under the aegis of a

committee in each district, but some person or group must assume responsibility for ensuring that the services function in a coordinated fashion, that there are consultants to whom professionals have access, and there is support in the form of information and guidance.

Concluding Comments

Finally, those professionals in training (students, interns, residents, and post-graduate fellows) who wish to devote themselves full-time to dealing with the elderly as a career, should be encouraged to do so. Recognition should be given by diploma or degrees for their special knowledge and skills. The Task Force learned that the medical profession is looking carefully at a specialization in geriatrics. Recognition of this sort requires that there be a distinct body of knowledge, that there be specialized consultants, that there be educators and researchers. Those wishing to specialize in teaching or research in the future should have many opportunities in the Ontario system of delivering health and social services, to increase their knowledge and to provide leadership in promoting further developments in service, education and research.

APPENDIX "A"

GLOSSARY

Adjuvant: a person who serves as an auxiliary in a residential care or treatment facility for elderly persons. In Ontario, a program of the Ministry of Community and Social Services since 1962, has resulted in the placement of approximately 200 such persons in 110 Homes for the Aged. Adjuvants are trained in basic methods of mental and physical activities of the elderly.

Aged, the Elderly: persons 65 years of age and over. This specific age has been commonly accepted in Canada because it corresponds to the usual or mandatory date of retirement of most persons, and the commencement of payment of the universal Old Age Security Allowance (Old Age Pension).

"young-old" – persons 65-74 years of age
"middle-old" – persons 75-84 years of age
"old-old" – persons 85 years and older

Chronic Care Hospital: a residential care facility providing health and social services on a long-term basis for elderly or other persons suffering seriously debilitating illnesses from which recovery or rehabilitation are highly unlikely.

Day Care facility: an organization, usually in the form of a community Day Care Centre or a part of a residential institution, which has a program for those elderly persons who require a modest level of care and supervision during the day on a scheduled basis, and provides a stimulating environment through social, physical and intellectual activities.

Day Hospital: a facility related to a hospital or other health care organization which has a program for those elderly persons requiring diagnostic, rehabilitation or other services during the day on a scheduled basis, and provides therapeutic services under the supervision of health care professionals.

Gerontology: the field and study of aging and the elderly in a very broad sense.

Geriatrics: the medical specializations emcompassing practice with elderly persons.

Gains: Guaranteed Annual Income Supplement – a program of financial assistance provided by the Government of Ontario to those elderly persons who, despite receipt of Old Age Security and the federal-provincial guaranteed income supplement, are deemed to have insufficient income to provide a modest but adequate standard of living.

Guaranteed Income Supplement: a federal-provincial program of income supplementation for those elderly persons who have little or no income beyond the universal Old Age Security Allowance. The program began in January, 1966 and is more or less routine, based upon a simple declaration of income received rather than a means test.

Home Care Program: "the organized provisions of health care services in the home," begun in Ontario in 1958 as a pilot project in Toronto, and since expanded to include Programs in 38 Ontario communities in 1978. Upon the recommendations of a physician, personal health and supportive service will be provided to enable elderly persons with acute (or chronic) illness to maintain themselves adequately in their own homes. Chronic Home Care has been under study in pilot projects and is available in 4 communities only in 1978.

Homes for the Aged: residential care facilities supervised in Ontario by the Ministry of Community and Social Services and financed in large measure under the Homes for the Aged Act and the Charitable Institutions Act, Ontario. Homes under public auspices may be under the jurisdiction of a county, municipal or regional government. In the larger urban centres there are homes developed, constructed and operated by voluntary organizations, secular and non-secular, which receive public financial support.

Nursing Homes: residential care facilities owned and operated by individuals or corporate entrepreneurs in Ontario under the supervision of the Ministry of Health. Persons who require at least 1.5 hours of nursing care per diem are referred by health care professionals. Each resident pays a per diem contribution amounting to about one-third of the approved cost determined by the Ministry, which pays the balance.

Old Age Security: the universal allowance or pension payable to all Canadians, 65 years of age and over, who have at least 10 years residence in Canada. The amount is adjusted quarterly in line with increases in the Consumer Price Index.

Senior Citizen Housing: self-contained housing accommodation designed and constructed specifically for elderly persons under the provisions of the National Housing Act. In Ontario, the responsible ministry is the Ministry of Housing, which has defined the age of eligibility as 60 years and over. Housing for senior citizens is operated and managed by 56 local or regional Housing Authorities in 1978, and located in more than 200 Ontario municipalities. In Metropolitan Toronto, the Metro Council exercises these responsibilities through the Metro Toronto Housing Company Ltd., a municipal non-profit corporation.

APPENDIX B

TWELVE GERONTOLOGICAL PRINCIPLES*

1. The elderly are a heterogeneous group with a variety of lifestyles and needs. They differ from one another more than they do from the young and even more than the young do from each other.
2. As far as possible elderly people should have a choice in determining their living arrangements as they grow older. They should be afforded an opportunity to plan ahead, with the assistance of adequate counselling for those periods in life when major change may be required.
3. The great majority of older people are relatively healthy and are living at home. Most of them are not disabled, dependent nor depressed.
4. Most older people have the desire and the potential to be productive, contributing members of society.
5. Human potential is not necessarily related to chronological age but much more related to such things as income, occupation, education and health.
6. There are different needs for health and social services between the "young-old" and the "old-old" and between elderly men and women.
7. Prevention of illnesses and accidents is always preferable to treatment and rehabilitation. It is not too late to begin to practice good health habits after the age of 65.
8. Most older people would prefer to be independent and to live in their own homes as long as possible.
9. Relocation of the elderly should be considered only when necessary and desirable and if required should be accompanied by social and psychological counselling and support.
10. Family support, accommodation and socio-economic factors are more important than health services in keeping the elderly independent.
11. Most older people feel that their condition in life is better than the greater public believes it to be.
12. Older people should always be given the opportunity of participating in decisions affecting themselves.

*Adapted from "Health Services for the Elderly", *Final Report of a Working Group of the Federal-Provincial Advisory Committee on* Community Health, August 1976, Page 9.

APPENDIX C

RECOMMENDATIONS

The Task Force on Health Care for the Aged recommends:

1. THAT the Government of Ontario enunciate its awareness of the increasing number and proportion of persons aged 65 and over to be expected by the end of the century and beyond, and despite existing financial constraints emphasize its commitment to provide adequate and appropriate health care and social and income maintenance services for the elderly. (ref. p. 23)

2. THAT the Government of Ontario in its research funding through the Ministries of Health and Community and Social Services, assign greater priority to studies of the elderly and pre-elderly population;

   and

   THAT all granting agencies encourage scientists to direct more research effort to the process of aging, particularly in the following areas:
   - Genetic aspects of aging;
   - Illness associated with age;
   - Specific effects of aging on the health of special population groups (ref. p. 24)

3. THAT the Ontario Medical Association consider negotiating a differential fee for OHIP payment to physicians for a multi-system assessment and complete examination of the elderly, because of the greater time that is required than for younger patients. (ref. p. 28)

4. THAT the College of Physicians and Surgeons of Ontario urge physicians, in association with other health professionals, to develop a plan with their elderly patients to ensure that their treatment needs are periodically assessed, that appropriate therapy is provided and that follow-up is arranged. (ref. p. 31)

5. THAT the Ministry of Health, district health councils and health professionals emphasize community and on-going care and effect a shift from the present technological and acute care orientation of health services. (ref. p. 32)

6. THAT the Ministry of Health commission on epidemioligical study to determine the common causes of accidents among the elderly and thus to suggest measures of prevention, since hip fractures, for example, are a major cause of the institutionalization of elderly people. (ref. p. 33)

7. THAT no acute treatment hospital be considered by the Ministry of Health for conversion into a chronic care facility unless an engineering study has first been conducted which demonstrates that the facility is appropriate and that it can be converted at a reasonable cost. (ref. p. 37)

8. THAT coordinators of senior citizens' services be appointed at the local level of health care and social services delivery, that is, the municipal level, to assist elderly persons and professionals working on their behalf, to secure the variety of different health and social services required, and to identify gaps and deficiencies. (ref. p. 38)

9. THAT the Ministries of Health and Community and Social Services encourage the functional integration of nursing homes, homes for the aged, chronic care hospitals and general hospitals. (ref. p. 39)

10. THAT the Ministry of Health give consideration to the payment of all or part of the cost of certain major dental procedures and prostheses for the elderly, eligibility to be determined on the basis of need. (ref. p. 43)

11. THAT the Ministry assist hospitals, other institutions and local official health agencies to develop dental clinics which would provide care for the elderly. (ref. p. 43)

12. THAT the Ministry of Health give consideration to the payment of all or part of the cost of hearing aids for the elderly, eligibility to be determined on the basis of need. (ref. p. 45)

13. THAT the Ministry of Health request the Ontario Society for the Deaf, the Canadian Hearing Society and hospitals which dispense hearing aids, to institute a program of follow-up service for those who have purchased (or received) such aids. (ref. p. 45)

14. THAT the Minister of Health request the Minister of Colleges and Universities to encourage an increase in the number of audiologists and support staff trained to deal with the increasing frequency of deafness in the population. (ref. p. 45)

15. THAT the Ontario Medical Association and the Ministry of Health encourage family physicians, general practitioners and personnel of local health agencies, to conduct regular visual appraisal of their elderly patients and referral for specialist eye examinations where required. (ref. p. 48)

16. THAT the Ministry of Health and Ministry of Community and Social Services consider arrangements for regular visual appraisal and referral for specialist eye examination where required, for all residents in nursing homes and homes for the aged in Ontario. (ref. p. 48)

17. THAT the Ministry of Health give consideration to the payment of all or part of the cost of eyeglasses for the elderly, eligibility to be determined on the basis of need. (ref. p. 48)

18. THAT the care in any long term care facility where there are mentally impaired elderly residents be built around the concept of reality orientation (a treatment modality emphasizing mental stimulation through social interaction concerning everyday life). (ref. p. 51)

19. THAT there be developed in long term care facilities, appropriately licensed and approved programs and environments for the protection and support of persons with impairment of mental health. (ref. p. 51)

20. THAT where freedom of movement is restricted (closed units) there be very clear procedures for periodic re-assessment and mechanism of right to appeal by the patient or his personal representative. (ref. p. 51)

21. THAT the Ontario Medical Association and the Ministry of Health identify ways in which health professionals can provide increased mental health services to the elderly, specific to their needs and problems, both in community settings and in residential institutions. (ref. p. 51)

22. THAT the Ministry of Health, the Ontario Medical Association and the College of Pharmacy jointly develop a mechanism for control and monitoring of the dispensing of drugs and medications to elderly persons at home or in institutions, to ensure safe use at reasonable cost. (ref. p. 53)

23. THAT the Minister of Health request the Ministry of Community and Social Services to give consideration to various mechanisms of dispensing drugs to institutions, including the capitation system for which a pilot program has been established in the Niagara Region. (ref. p. 53)

24. THAT the Ministry of Health institute a review to determine avoidable excessive costs of the Drug Benefit Program as it exists at present. (ref. p. 53)

25. THAT the previous recommendations of the Ontario Council of Health, in Council's Report on Chiropodists in Ontario, 1973, be implemented; and,

    THAT the Minister of Health request the Minister of Colleges and Universities to take steps to increase the number of chiropodists available in the Province by the establishment of educational programs in the Colleges of Applied Arts and Technology. (ref. p. 55)

26. THAT the Ministry of Health permit chiropodists to offer their services, after licensing, within a defined scope of practice. (ref. p. 55)

27. THAT greater emphasis be placed on the importance of foot care for the elderly and, to this end, the appropriate Ministries encourage nursing homes and other institutions to recruit qualified chiropodists to serve residents and members of the community on a part-time basis. (ref. p. 55)

28. THAT the Health Manpower Planning Section of the Ontario Ministry of Health continue and strengthen its effort, with the advice and assistance of the Human Resources Committee, Ontario Council of Health, to establish the balance or imbalance between supply and demand and to encourage proper distribution among the health care professions required to serve elderly persons over the next three decades; and to develop health manpower plans to meet estimated staffing requirements. (ref. p. 59)

29. THAT the Health Manpower Planning Section of the Ontario Ministry of Health establish a formal relationship with the Senior Citizens Branch and Office on Aging, Ontario Ministry of Community and Social Services, to explore the supply of and demand for members of social service professions and related occupations required to serve elderly persons now and in the future, and to develop the framework for and the process of manpower planning within the Ministry. (ref. p. 59)

30. THAT the Ministry of Health undertake a study of the current supply and probable requirements for chronic hospital and nursing home beds, by five-year periods during the balance of the century, and develop plans to provide required institutional facilities through new private construction, expansion of existing homes and appropriate conversion of existing buildings in the community to such uses; and (ref. p. 59)

31. THAT the Ministry of Health request the Ministry of Community and Social Services, perhaps jointly with the study of chronic hospitals and nursing homes, to undertake a study of the current supply and probable requirements for beds in homes for the aged, by five-year periods during the balance of the century, and develop plans to provide such institutional facilities as are required in appropriate locations. (ref. p. 60)

32. THAT the Ministry of Health expand Home Care Programs to provide better total care in elderly persons' own homes, in order to prevent unnecessary institutionalization; and (ref. p. 70)

33. THAT the Ministry of Health make Home Care Programs more accessible for people in need of long term care, on the assumption that the further evaluation of the pilot projects offering home care to chronic patients in Hamilton, Kingston and Thunder Bay, supports the expansion of Chronic Home Care. (ref. p. 70)

34. THAT the Ministries of Health and Community and Social Services jointly assess the problem of providing home care in rural areas and take appropriate action. (ref. p. 70)

35. THAT any decrease in institutional costs resulting from the development of community services must be accompanied by the transfer of appropriate resources to provide adequate support services in the community through the Ministries of Health and Community and Social Services working in cooperation. (ref. p. 71)

36. THAT the Ministry of Health, in cooperation with the Ministry of Community and Social Services, establish Placement Coordination Services, with relationships to District Health Councils and municipal governments, for each area, district or region of the Province, to achieve the following purposes:

    - To act as a knowledgeable focal point to permit advanced planning for any move from home to institution or between institutions;
    - To coordinate the care of the elderly person and ensure that people are placed in the best level of care and location to suit their needs;
    - To avoid unnecessary or premature institutionalization by ensuring that all community resources have been considered;
    - To ensure that a patient is moved through levels of care, with ease and at the appropriate times;

– To ensure that no person is discharged from any institution until the family or other organization has had adequate time to prepare for the discharge. (ref. p. 77)

37. THAT the Minister of Health impress upon the Government of Ontario the urgent need to develop a new coordinating mechanism for services for the elderly, perhaps reporting to the Provincial Secretary for Social Development, with at least the following direct functions:

(1) to identify the requirements for health, social, housing, educational and recreational services throughout the province;

(2) to coordinate all regional (local) health and social service programs provided for the elderly;

(3) to establish standards and evaluate such health and social service programs;

(4) to provide consultation and support services for the offices at the regional level; and (ref. p. 80)

38. THAT the Government of Ontario delegate responsibility to the regional or district health council level throughout the Province to:

(1) encourage the development of essential health, social, recreational and educational services for the elderly at the level of the community;

(2) develop and administer an information service about health and social services for the elderly within its geographical jurisdiction;

(3) facilitate volunteer programs for and by the elderly to strengthen the capacity of older people to live at home in the community. (ref. p. 80-81)

39. THAT the Government of Ontario provide adequate and flexible funding at the regional level for services to the aged, to include health, social services, housing, and other programs. (ref. p. 83)

40. THAT regional authorities be given much more direct responsibility for the coordination, and in some cases supervision, of community health and social services (e.g. nursing homes, homes for the aged, and lodging homes for the elderly) in areas under their jurisdiction. (ref. p. 83-84)

41. THAT the Minister of Health request the Minister of Community and Social Services and the Minister of Colleges and Universities to encourage the Colleges of Applied Arts and Technology to

strengthen and/or develop courses designed to train students such as social service aides and health care aides to work with elderly people who require assistance to maintain residence in their own homes in the community; and (ref. p. 88)

42. THAT the Ontario Welfare Council and the various Social Planning Councils and Volunteer Centres throughout the province work co-operatively to develop a curriculum for volunteers, including elderly people themselves, who wish to assist older persons to fulfil the requirements of daily living in the community. (ref. p. 88)

43. THAT the Ministry of Health make resources available to the five Ontario Universities which now maintain a Health Sciences Centre to establish a professorial chair of geriatrics within the Faculty of Medicine and a Department of Geriatrics; and (ref. p. 89)

44. THAT at least one Ontario University with appropriate resources in the health and social sciences establish an Institute of Gerontology to strengthen teaching and to foster research in the broad field of aging. (ref. p. 90)

45. THAT the Universities of Ontario, within their Faculties or Schools of medicine, dentistry, occupational therapy, physiotherapy, speech therapy, nursing, social work, and health administration, ensure that all health professionals have adequate training in geriatric care and that, in addition, geriatric specialists should be available for further consultation. (ref. p. 91)

46. THAT the Ministry of Education and the Ministry of Colleges and Universities ensure that information on aging and its effects be provided in educational curricula for students in secondary, post-secondary and university programs in Ontario. (ref. p. 92)

APPENDIX D

THE RELATIONSHIP OF HEALTH CARE PROFESSIONALS TO THE ELDERLY PERSON

It has been stated already that elderly persons, particularly those in extreme old age, may manifest (in addition to general frailty) impairments in physical health, in mental competence and in the ability to cope with the stresses and losses that often occur in late life. The health professionals must be prepared, therefore, not only to provide a service in the area of their special expertise but to take a broad approach to the whole person and render not only care and treatment but understanding and concern. In some cases the problems are complex, difficult and continuing, and more than one health professional is needed. It is essential that these professionals communicate well with each other and be aware of and support what each is doing through a team approach. In this way the old person is seen as a whole person and the management of each problem is appropriately coordinated. Health professionals should understand the health care system; be able to identify what services would be useful for the patient and be able to guide the patient to obtain them.

In their training, health professionals gain special expertise in designated areas of knowledge but also gain a general understanding of health problems and their emotional and functional consequences. This is necessary so that they can understand their patients as persons and be aware of their general needs as well as those needs specific to the field of knowledge of that professional. However, when working in a team approach, the health professional must be aware that his area of general knowledge will overlap with that of other professionals. Therefore, the team and team leader must decide in a particular case which professionals will be responsible for the general management and what specific expertise is to be provided by each. Moreover, each professional must evaluate his role and effectiveness in the team to ensure that he is not so involved in general management as to lack time or availability to provide the contribution of expertise that only he can provide. Conversely, if the professional is not required to provide a specific expertise it may be possible to ensure that others are providing general management.

In the education of health professionals information on the biology of aging, illnesses of late life, psychological and social aspects of aging and an overview of the position of the aged in society should be provided to all. In addition, training in the general management of an elderly

patient or client and in specific skills appropriate to the health discipline, should be provided. They should also be trained in working with others in a team, in sharing and cooperation in management and in evaluating their contribution and effectiveness.

It must be stated that many professionals lack competence and even interest in the problems of the elderly but this lack is not specific to or characteristic of any particular professional group. Following is an indication of the functions and special competencies of various components of health care which would be involved in helping elderly people.

(a) Medicine

The physician has special training in the diagnosis of physical and mental illness, in understanding the underlying derangement of body functioning or development and in identifying the medication or specific therapy that may prevent, delay, cure or ameliorate the condition. He understands the anticipated course of the illness and can inform the person on what action to take in anticipation. The old person's family physician may have a knowledge and understanding of the person based on many years' of contact and many shared experiences, thus he may be in a unique position of trust and respect to provide guidance and counsel. The physician has the legal authority to admit and discharge patients from treatment programs paid from public funds. The licensed physician has legal authorization (as do dentists, nurses, physiotherapists, chiropractors and oseteopaths) to carry out treatments on persons within the limits of his expertise and with the patient's consent.

(b) Nursing

The nurse has specific training in offering assistance with personal care required for the activities of daily living and in helping persons and their families cope with actual or potential stressful situations which impinge upon their health status. Such stresses arise from developmental factors or alterations in their life situations, such as chronic illness. A traditional aspect of the nursing role has been the facilitation of the medical management of disease processes through case-finding, monitoring illness states, implementing the medical treatment plan, and teaching the patient how to care for himself using the medical plan as the guideline.

Nurses practice in all institutional and community health care facilities and thus have contact with both well and ill older persons. They can provide a consistent contact between the older person and the health care system. The nurse can activate and coordinate support systems and

health maintenance programs which make it possible for many elderly to remain in the community. For those elderly who are institutionalized in long term care facilities, these nursing skills can be used to maintain the maximum degree of functional competence as well as fostering a sense of personal dignity.

(c) Physiotherapy

The physiotherapist has specific training in body mechanics and function relating to maintenance of posture and physical movement and the derangements caused by injury, illness or abnormal development. He is trained to provide instruction and treatment to correct or improve defective structure and function, using such modalities as exercise, heat in various forms, splints and prostheses. For the elderly person the physiotherapist may improve balance, gait, range of movement of a limb, relieve pain and improve exercise tolerance. He may also teach the person how to get up and about despite some handicap or may instruct others in how to assist the person to do this. Physiotherapists provide services not only in hospitals but in residential care facilities and private homes. The Task Force invited an address from a representative of the discipline.

Because of her experience and knowledge in the field of rehabilitation, the physiotherapist addressing the Task Force was aware of certain deficiencies in the health care system at present that prevent members of the profession from providing their services to the elderly to the extent that would be beneficial to the Province as a whole.

These included:

1. There are not enough programs that aim to support the elderly at home by assisting them to increase or at least maintain their physical and mental functional capacity.
2. There is a scarcity of skilled professionals to work with the elderly in order to enable them to remain at home instead of entering an institution for long term care.
3. Elderly persons are often admitted to a facility for long term care without a clear assessment of their potential for improvement with treatment such as physiotherapy, either before or after admission.
4. Although physio- and occupational therapy may be available in long term care facilities in Ontario, there is need for an increase in supply of such services.
5. Staff in long term care facilities need instruction and encouragement in maintenance of activity of function of elderly residents.

6. Both health professionals, such as physicians, and family members need information on services already in existence which could be used for the elderly more appropriately than they are at present.

(d) Occupational Therapy

The occupational therapist uses the modality of occupation in tasks such as activities of daily living, woodworking, office work, dressmaking, collating, assembly of articles or group activities to identify and remedy impairments in physical and/or mental function and problems of an emotional or social type. He may also use splints or protheses to improve function. Perceptual testing and evaluation of mental function using specific test materials may also be done. In dealing with the elderly person, the occupational therapist can contribute to the assessment and management by determining how well the person functions in a setting or using objects familiar to him and when asked to advise if modifications are required to facilitate the old person managing there.

The occupational therapist also can identify social causes of breakdown such as isolation and lack of meaningful occupation and may assist the elderly person to find an interesting activity. He may provide pre-retirement counselling to prevent such a situation. The occupational therapist has the ability to engage the elderly person's interest by using occupations familiar to the person or that appear as a "natural" activity.

(e) Social Work

Although social work is not usually considered a health care profession an important proportion of professionally trained social workers (practitioners who have attained a Bachelor's or Master's Degree in Social Work) are employed in health care settings in Ontario. Certain social work services are available to the elderly in acute general hospitals, psychiatric hospitals and in a variety of public or voluntary treatment centres offering service to persons with emotional disturbance, mental retardation and in general, individuals and families whose social functioning is impaired by virtue of physical, emotional, social, financial or environmental circumstances.

Social work has been defined as "the art of bringing various resources to bear on individual, group, and community needs by the application of a scientific method of helping people to help themselves". Traditionally, social work has been closely related to the meeting of financial needs, and the general public has been slow to realize that economic security and income maintenance have become major public responsibilities and are not synonymous with social work.

Within the public segment of the health care system serving the elderly, social workers are primarily employed in general hospitals where the pattern is for the physician to treat the patient and the social worker to meet with members of the family and the patient to discuss and to plan for the next level of care. This may involve his return to home and to the community; or it may mean a move to a convalescent home, nursing home or chronic care facility. In any case the social worker's task is to deal with the feelings of the patient and his family as they contemplate the social and other impacts of these changes.

In the voluntary sector social workers are engaged in counselling services and in social and recreational programs for the aged. Many of the major residential facilities including homes for the aged, particularly those which offer several levels of care, have developed substantial departments of social work.

Whether in the public or voluntary sector social workers very often function as members of treatment teams. Such groups, characteristically, consist of a physician or psychiatrist, a psychologist, a nurse and a social worker, with the responsibility of developing both a treatment program and future plans for the older patient.

(f) Dentistry

The major functions of dentists include restoration of otherwise sound teeth after decay has been removed, removal and replacement of teeth which are beyond repair, teaching and encouragement of patients toward the prevention of dental caries and periodontal disease, and the identification of other problem conditions in the mouth which may require medical attention.

Until recently (the early 1960's) the conventional wisdom held that elderly persons required minimal dental service. It was generally believed that every person lost most or all of his natural teeth by the time he was 60 years of age, that most people wore complete sets of dentures by their middle or late '60s and only rarely required the assistance of a dentist in fitting, modifying or replacing such prostheses. Moreover, it was considered that prevention of these typical patterns of dental loss was virtually impossible.

The Task Force learned that all of these suppositions are incorrect and/or will rapidly be discarded as larger numbers of Ontario residents reach age 65 and over by the end of this century. More older people than in the past are retaining some teeth, a fact which can assist the dentist in developing better-fitting dentures and a more natural facial appearance.

Prevention is no longer considered impossible, and the "young-old" group by the turn of the century may have benefitted substantially from recent stress on dental health and prevention associated with the development of topical and paste fluorides. This practice of dentistry will inevitably include a far greater proportion of persons age 65 and over than now pertains.

(g) Pharmacy

Physicians frequently prescribe one or more medications for the elderly patient and often these are renewed and continued for prolonged periods. The pharmacist working in the hospital or in a community pharmacy dispenses these medications. He is thus in a position, through frequency of contact, to play an important role in the delivery of health care. His education in the basic sciences and health sciences, as well as his clinical training, should provide an understanding of the action of various drugs and medications in the human system, of the dangers inherent in the ingestion of incompatible drugs and of the importance of offering proper instruction to the patient.

A health care team based in an institution may work closely with a professional pharmacist since there are departments of pharmacy in major hospitals and certain institutions. Patients in their own homes or in residential institutions usually receive prescriptions dispensed by a community pharmacist. In either case the importance of accurate identification of the patient and the drug, and absolutely clear instructions as to frequency and amount of dosage, are essential to the health and recovery of the patient. In the community itself, pharmacists are strengthening their potential role as the monitors of drug usage among ambulatory and homebound clients — a matter of particular significance for elderly persons.

Summary

The delivery of health care to the elderly person is the responsibility of every health professional although there are two major approaches to the method of practice. There is, in the first instance, the traditional mode of practice in which an independent private practitioner offers service to individuals who seek his services or are referred by other professionals. This group includes most physicians, dentists and pharmacists, although there are a few private practitioners among nurses, physiotherapists and social workers.

There has been developing within the past three decades, a second mode of treatment of elderly persons which involves the creation of treatment

teams which include members of several health care and related professions. The team concept is most advanced in acute general and chronic hospitals but is gaining acceptance in a variety of institutional settings (convalescent homes, nursing homes, and homes for the aged), and in Home Care. The advantage of the team approach rests in the twin opportunity of bringing to bear the expertise of professionals from different disciplines, and of involving members of the family and perhaps the friends of the elderly patient, in the treatment plan and program.

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ISBN 0 - 7743 - 3372 - 3